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A 5-year project to develop public health services for migrant workers was initiated in Florida in 1956. The project staff consisted of 8 public health personnel: 2 public health nurses, a public health educator, a public health nutritionist, a medical social worker, a part-time sanitarian, a liaison worker, and a secretary. Two practicing physicians (a pediatrician and a general practicioner) served as medical consultants in the clinical activities of the project. The data were collected by personal interviews and observations although the study aspects of the project were secondary to the service functions. Project activities included a survey of 320 migrant housing establishments in western Palm Beach County, family medical examinations and treatment, maternity education and care programs, and a dental survey. This monograph presents a detailed description of the project, its activities, and findings. (SF)

FLORIDA STATE
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MONOGRAPH
Number 2

ON
THE
SEASON

R. H. BROWNING
T. J. NORTHCUTT, Jr.

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ON THE SEASON

A report of a public health project conducted
among Negro migrant agricultural workers in
Palm Beach County, Florida

ROBERT H. BROWNING
TRAVIS J. NORTHCUTT, JR.

Florida State Board of Health Monograph No. 2
1961

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Migrants "on the season"

This volume is dedicated to the late Earl Lomon Koos, Ph.D., whose professional and personal interest in migratory farm laborers was largely responsible for the initiation of the project about which this report is concerned.

FOREWORD

There has been during the past decade an increasing concern with the development of research within the public health environment in Florida. During this period an Entomological Research Center was authorized, constructed, the staff of scientists assembled and a unique research organization activated; already the facilities have been expanded. The Bureau of Laboratories alone and also in cooperation with other bureaus and divisions has contributed to a number of valuable studies. Local health departments have displayed increasing interest and major studies have been undertaken by the larger departments. Support has been derived predominantly through National Institutes of Health research grants. A regular state appropriation does provide major support to the Entomological Research Center, and bureaus and divisions in the course of their regular work find it possible or even essential to carry through pertinent investigations as a natural and important part of rendering superior health services. Despite this evidence of progress, it is recognized that obvious research needs and opportunities are only beginning to receive the attention indicated. Further development of community-based studies is anticipated.

The value of research is dependent not alone on the quality of the observations but also on the accessibility of findings to other investigators and to those who will use the findings for the improvement of public health practice. We have deemed it essential to assure that a suitable medium for the reporting of research findings would be available. It was felt there would be particular value in relatively detailed, comprehensive reports of completed studies. National scientific journals are not available for such manuscripts. It was concluded that a monograph series which would make available the findings of the Florida State Board of Health studies would be warranted. The research grant overhead funds proved to be sufficient to cover the costs of publication. The monographs will be distributed without cost to libraries and to a selected mailing list; copies will be available to individuals requesting them.

The first two monographs of the series report the findings of studies concerned with migratory agricultural laborers. Monograph No. 1, *They Follow the Sun*, was originally published as a separate volume in 1957; requests for copies exceeded expectations, and we are now complying with repeated suggestions that this work of the late Dr. Earl Koos be re-published. This work provides a summary of the nature of the problem, emphasizing the socio-cultural aspects. *On the Season,* Monograph No. 2, reports the findings of a five-year project concerned with the development of health services adapted to the social and cultural characteristics of farm migrants. It is hoped that the findings of these studies will be of interest and value to all concerned with the provision of health care to migratory agricultural laborers.

Wilson T. Sowder, M. D.
State Health Officer

PREFACE

THE PHENOMENON of migratory agricultural labor is receiving, increasingly, public and private attention. There is growing interest in the varied and complex problems associated with the individuals whose lives are characterized by perennial movement which necessitates continuous and repeated adjustments to many different communities. There is like concern for the communities which, seasonally, are faced with additional hundreds, even thousands, of persons who place additional demands upon local public and private resources. One of the problem areas faced by migrants and the communities which attract them is that of public health—the subject of this publication.

In the Palm Beach County (Florida) Health Department a public health project was conducted among a selected group of agricultural migrants for a period of five years. The project was staffed by a multi-disciplinary public health team which sought to determine accurately the health needs of the migrants and to develop services to cope with the established health needs. The findings of the project are reported in the following pages.

The information and experience acquired during the course of the project has resulted in marked improvement of health services to migrants in Palm Beach County. Actually, a general improvement of all programs of the Palm Beach County Health Department has been observed since the beginning of the project.

The information presented in this report should be of immediate interest not only to those providing health services to agricultural migrants but also to others generally concerned with this social problem.

C. L. BRUMBACK, M.D., *Director*
Palm Beach County (Florida) Health Department

ACKNOWLEDGMENTS

THE SUBSTANCE of this report is the result of contributions by many individuals. We should like to acknowledge by name and position the members of the Migrant Project Staff whose contributions made this report possible. They are: Ovelle Thomas (1956-59) and Margaret Taylor (1959-61), medical social workers; Mea Bosworth and Ivory Reynolds, public health nurses; Barbara McDonald (1956-57), Graciela Delgado (1957-59) and Mary Anne Marshbourne (1959-61), public health nutritionists; William Braatz, sanitarian; Mattie Leland, liaison worker; Amy Geckler, secretary.

Governor Witt, M.D., and John Lampkin, M.D., both private practitioners, made invaluable contributions in conducting the migrant clinics from which much of the data came. C. L. Brumback, M.D., Director, Palm Beach County Health Department, held the *general responsibility* for the administration of the project; his own intellectual curiosity served to inspire the project staff.

For their helpful suggestions in reviewing the manuscript, our thanks go to the following personnel of the Florida State Board of Health: A. V. Hardy, M.D., Assistant State Health Officer; L. L. Parks, M.D., Director, Bureau of Maternal and Child Health; E. L. Flemming, Ed.D., Assistant Director, Bureau of Maternal and Child Health; Mary Brice Deaver, Director, Division of Nutrition; Elizabeth Reed, Director, Division of Health Education.

We wish to acknowledge that the financial support for the project was provided by a grant from the Children's Bureau, U. S. Department of Health, Education, and Welfare.

R.H.B.

T.J.N.

CONTENTS

CHAPTER PAGE

I Introduction 1

II Migrants and their Life Situation 5

III Migrants and their Physical Environment 19

IV Health and Health Care of Migrants 29

V Working with Migrants 45

VI Summary 61

TABLES

Tables

1 Place of Birth, 544 Negro Farm Workers, Palm Beach County, Florida, 1956-60. Page 5

2 Marital Status, 880 Adult Negro Farm Workers, Palm Beach County, Florida, 1956-60. Page 6

3 Number of Absences of 53 Migrant Children as Reported by School Officials, Belle Glade, Florida, January 1—Close of School Term, 1955. Page 14

4 Living Arrangements, 346 Negro Households, Palm Beach County, Florida, 1956-60. Page 19

5 Amount of Weekly Rent Paid by 354 Negro Households, Palm Beach County, Florida, 1956-60. Page 20

6 Distribution and Condition of Excreta Disposal Facilities, 320 Migrant Labor Housing Establishments, Palm Beach County, Florida, 1958-59. Page 22

7 Physical Abnormalities among 862 Negro Patients by Migration Status, Migrant Project Family Clinics, Belle Glade, Florida, 1957-59. Page 30

8 Distribution of Food Intake in Relation to Recommended Dietary Allowances of the National Research Council, 5th Grade Students, Okeechobee Elementary School, Belle Glade, Florida, 1959. Page 36

9 Dental Health Status, 138 Negroes, Belle Glade Florida, 1959, by Age Group. Page 37

10 Results of Migrant Labor Tuberculosis Chest X-ray (70 mm) Screening Surveys, Palm Beach County, Florida, 1958, 1959, 1961. Page 38

11 New Cases of Tuberculosis by Stage and Activity, Migrant Labor Chest X-ray (70 mm) Screening Surveys, Palm Beach County, Florida, 1958, 1959, 1961. Page 38

12 Old Cases of Tuberculosis by Stage and Activity, Migrant Labor Chest X-ray (70 mm) Screening Surveys, Palm Beach County, Florida, 1958, 1959, 1961. Page 39

13 Results of Blood Test Surveys Among Migrant Farm Workers, Palm Beach County, Florida, 1959 and 1961. Page 39

14 Delivery Plans Compared with Actual Delivery, 763 Negro Maternity Patients, Belle Glade Health Center, Palm Beach County, Florida, 1957-60. Page 42

15 Concepts of Selected Health Entities, 42 Negro Patients, Belle Glade Health Center, Palm Beach County, Florida, 1958-59. Page 49

16 Selected Health Terms in Order of Non-readibility, 43 Negro Patients, Belle Glade Health Center, Palm Beach County, Florida, 1958-59. Page 50

CHAPTER I

INTRODUCTION

THE PHRASE "on the season" is used by Negro migrant farm workers to denote their engagement in seasonal farm work. Along the Atlantic seaboard, farm migrants are on the season from southern Florida to upstate New York, moving from place to place in response to the demands of seasonal farm activities. It is estimated that some 50,000 workers comprise the migratory farm force known as the "Atlantic Coast Migrant Stream."

Florida, the southern terminus of the stream, is considered to be the "home base" of Atlantic Coast migrants. Each fall thousands of migrants come to Florida to find work in the vast vegetable and citrus industries. Forty of Florida's 67 counties (59.7 per cent) use seasonal farm labor.[1]

For a number of years the Florida State Board of Health and the county health departments have been concerned with the public health implications of the annual influx of thousands of migrant farm workers. In 1954, the State Board of Health, through its Bureau of Maternal and Child Health, conducted a study to determine the day-by-day problems which confront agricultural migrants and the ways which migrants attempt to meet these problems. The late Dr. Earl Lomon Koos, then consulting social scientist, State Board of Health, and Professor of Social Welfare, Florida State University, directed the study which is reported under the title of *They Follow the Sun,* Florida State Board of Health, 1957.

In 1956, the Children's Bureau of the U. S. Department of Health, Education, and Welfare provided a grant to the State Board of Health for a five-year program to develop public health services adapted to the social and cultural patterns of migrant farm workers and to provide these workers with health services. The project extended from July 1956 until July 1961; it functioned as a part of the Palm Beach County Health Department and had the consultative services of the Bureau of Maternal and Child Health and the social scientist[2] of the Florida State Board of Health. This volume, *On the Season,* reports the findings considered of broad interest.

The setting of the project was in Belle Glade, Florida, a city of 11,000, located on the southeastern shore of Lake Okeechobee in Palm Beach County which has an area of some 2700 square miles.

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[1] U. S. Public Health Service. *Domestic Agricultural Migrants in the United States.* Map. Pub. No. 540, rev. Washington: Government Printing Office, 1960.

[2] The co-author (TJN) is the person referred to.

In the Lake Okeechobee region of the county there are thousands of acres of black rich muck (soil) referred to locally as "black gold." Belle Glade is the heart of this region from which, each winter, thousands of carloads of fresh vegetables are shipped to all parts of the country, leaving little doubt that Belle Glade is the "Winter Vegetable Capital of the World." This area was selected as the site of the project because of the annual influx of thousands of migrant farm laborers who come to find work in the vast vegetable fields. It is estimated that 15,000-20,000 migrants come each year to Palm Beach County. More than half of these come to Belle Glade and vicinity.

The activities of the project were concentrated in two geographic areas—one in the City of Belle Glade; the other in a nearby farm labor camp operated by the Belle Glade Housing Authority and known locally as Okeechobee Project. The Okeechobee Project has facilities for housing approximately 1800 persons. The population of the camp consists mostly of family groups. Single farm workers comprise a minority of the camp population. In the other project area, a Negro section within the municipal limits of Belle Glade, it is difficult to estimate the number of agricultural migrants. There are approximately 6000 to 8000 Negroes living in this area, most of whom work in agriculture. The actual number of migrants living here is undetermined. Some migrate annually, some occasionally; others have never migrated since coming to Belle Glade. Though the activities of the project were concentrated in two relatively small geographic areas, the service activities were not withheld from persons who lived outside these areas.

The project staff consisted of eight public health personnel: two public health nurses, a public health educator,[3] a public health nutritionist, a medical social worker, a part-time sanitarian, a liaison worker and a secretary. Two practicing physicians—a pediatrician and a general practitioner—served as medical consultants in the clinical activities of the project. The project staff had access to the services of the personnel of the State Board of Health and the Palm Beach County Health Department.

A multi-disciplinary approach was used in developing and providing health services to migrants. The staff focused their particular skills on the health problems of the project population in a collective attempt to attain the objectives. They also assisted local health department personnel in many of their activities. The medical social worker, nutritionist and health educator also served as consultants to the staff of the Immokalee Health Center of the Collier County Health Department. Immokalee is located approximately 70 miles southwest of Belle Glade. Migratory farm labor is widely used in that area where, as in Belle Glade, vegetable farming is a major industry.

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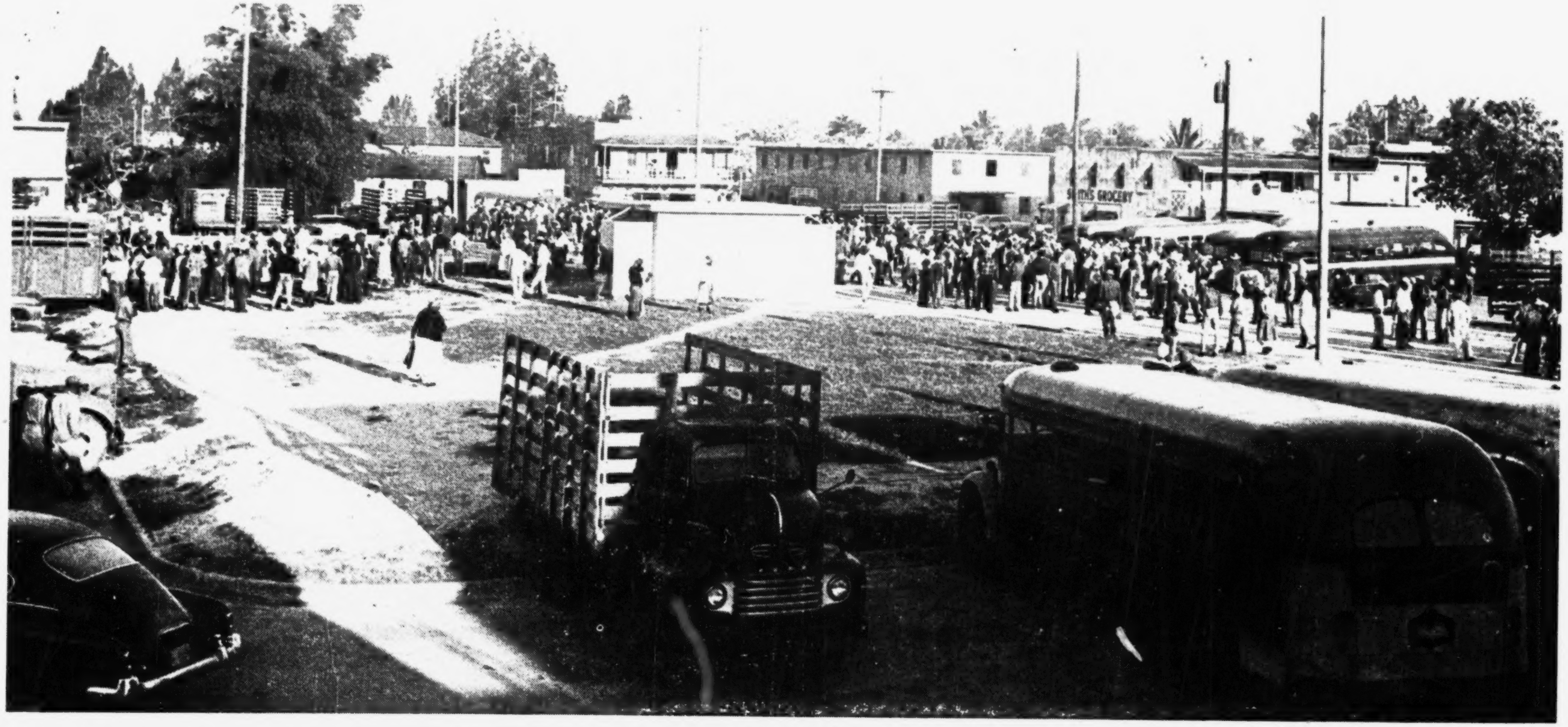
[3] The co-author (RHB) is the person referred to.

The data presented in this report were collected by personal interviews with and observation of members of the project population—Negroes residing in the two specified geographic areas. Hence, the terms "migrants" and "members of the project population" are essentially synonymous unless specifically stated to the contrary.

The study aspects of the project were secondary to the service aspects. However, this report is concerned with presenting observations made and data collected while providing health services to migrant farm workers. No attempt is made to present a report of service activities.

The mobility of migrants and difficulty encountered in interviewing, e.g., insufficient time to complete interviews at one visit, poor interviewing conditions in migrant living quarters, etc., resulted in incomplete information on many of the households. However, certain data were obtained; certain observations were made. These are presented in the following pages in the hope that they will be of value to the many individuals interested in migrant farm workers.


SMITHS GROCERY

The Loading Zone

CHAPTER TWO

MIGRANTS AND THEIR LIFE SITUATION

IN ORDER TO WORK effectively with migratory agricultural workers, public health employees need considerable knowledge of this group—of their characteristics and their background and of the circumstances under which they work and live. In this chapter information concerning Atlantic Coast migrants is provided; the discussion of the significance of this information for public health personnel is left to later chapters.

Migrants in the Atlantic Coast Stream

Although an increasing number of Puerto Ricans and other "whites" are now entering the Atlantic Coast Migratory Stream, it is estimated that Negro workers still constitute 90-95 per cent of the labor force of the stream. For this reason the present project was concerned primarily with the health of the nonwhite workers and their children. As Table 1 indicates, approximately 95 per cent of the nonwhite workers in the study were born in Southeastern United States, with over 50 per cent coming from Georgia. In most instances they come from rural agricultural areas, often directly from farms. In the early stages of the current project it was found that 63 per cent of the migrant householders had never done non-agricultural work. At that time only 29 per cent of the male householders had worked outside of agriculture as compared to 51 per cent of the female householders. Apparently this difference is due to the demand for Negro women as domestic servants, whereas, until recently, there have been few job opportunities open to Negro males outside of agriculture.

TABLE 1

Place of Birth of 544 Negro Farm Workers
Palm Beach County, Florida, 1956-60

Place of Birth	Number	Per Cent
Total	544	100.00
Georgia	282	51.8
Florida	97	17.8
Alabama	68	12.5
South Carolina	42	7.7
North Carolina	13	2.4
Mississippi	9	1.7
Virginia	3	.5
Other States	25	4.6
Foreign	5	.9

By modern standards the group is poorly educated. The median grade completed by the adult workers seen during the current project was 6.4. In general there is a tendency for the adult females in the group to have more education that the adult males. In an earlier study of East Coast migrants, it was found that 27 per cent of the adult males had no formal education as compared to 10 per cent of the females.[1] Thirty-one per cent of the females in the present study group had nine or more years of education as compared with 12 per cent of the males.

Household Characteristics

Many of the migrant households are quite large. Among 610 households studied during the current project, 43 (7.1 per cent) consisted of 10 or more persons and 81 (13.3 per cent) were single person households. The average (mean) number of persons per household was 3.8; if the single person households are excluded, the average size of the households is 5.4 persons.

As is found among other rural Negro groups, many of the migrant households have a female household head. In an earlier study of a large labor crew in the East Coast Stream,[2] it was found that 36.4 per cent of the households consisting of more than one person were headed by a female. Of these, over half (58.3 per cent) had no adult male who could be considered as a husband; the remaining 41.7 per cent had an adult and unrelated male present but taking a secondary role. Although it was not determined whether these males were husbands in the conventional sense, it was generally known that some of them were only temporarily affiliated with the households. While it is known that "serial monogamy" is practiced among the group,[3] no attempt was made in the current project to determine the prevalence of this practice. No special attention was given to the study of the marital relations and marital history of the workers. In most instances the staff accepted the worker's statement regarding his marital status. The following is the reported marital status of 880 adult Negro farm workers seen during the project.

TABLE 2

Marital Status, 880 Adult Negro Farm Workers, Palm Beach County, Florida, 1956-60

	Male		Female		Total	
Status	Number	Per Cent	Number	Per Cent	Number	Per Cent
Total	436	100.00	444	100.00	880	100.00
Single	58	13.3	64	14.4	122	13.9
Married	329	75.5	326	73.4	655	74.4
Widowed	13	3.0	18	4.1	31	3.5
Divorced	2	.5	2	.5	4	.5
Separated	34	7.7	34	7.6	68	7.7

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[1] Travis J. Northcutt, *The Social Characteristics of a Group of Migrant Agricultural Workers.* Unpublished M.S. thesis Florida State University 1955. pp. 62-64.

[2] Northcutt, *Ibid.* pp. 45-46.

[3] Earl L. Koos, *They Follow the Sun,* Jacksonville: Florida State Board of Health 1957, p. 18.

These data reflect the *reported* marital status of the workers *at the time they were interviewed;* no attempt was made to verify their reported status nor to investigate their marital history. The term "marriage" as used by this group does not always mean that the union was legalized through a civil or religious ceremony. In many instances it merely means that the couple has been living together for some time. Migrants who are not currently living with a person of the opposite sex often report that they are single despite the fact that they have been a partner in one or more common-law unions that have not been legally dissolved.

Another notable characteristic of migrant householders is the frequency with which they contain grandchildren, nieces, nephews, in-laws and distantly or non-related individuals. Approximately one-fourth of the individuals who migrated with the labor crew studied in 1954 were more distantly related to the head of their household than spouse or child.[4]

While allusions are frequently made regarding the instability of migrant households, little effort has been made to date to study the situation systematically. As in most cultural groups, there appears to be wide variations in the stability of the households. In an earlier study, Koos[5] found that there were similarities and differences which suggested the existence of two general types of families. He termed these "stable" and "unstable"; the major characteristics of each were as follows:

> The "stable" households: In these the members were industrious and conscientious. They saved money and made some effort to prepare for times of unemployment. They prepared food systematically, kept their personal quarters orderly and clean and did their laundry regularly. They gambled little, if at all, and did not drink excessively. They showed some concern for the children's welfare (where such were present) and made at least minimal efforts to have them attend school and church.
>
> The "unstable" households: In these the working members were unreliable and often had to be urged strongly to go into the fields. They rarely had any cash, borrowed from other migrants or from their employer whenever possible, frequently were inveterate gamblers and heavy drinkers. They were unclean in their habits and generally disorderly. Where children were present in the household, they were fed and cared for in a casual fashion, and the children's attendance at school was not of any particular concern.

As would be expected, not all of these characteristics were present in every household, whether stable or unstable, but in general they were present so often that they appeared to constitute patterns. The assignment of the 202 households to these two categories was determined both by members of the project staff and by independent readers of the case records. The findings were as follows:

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[4] Northcutt, op. cit., p. 47.

[5] Koos, op. cit., p. 18-19.

	Stable	Unstable
Multi-person household with male head	19	26
Multi-person household with female head	27	5
Two adults, same sex	2	10
Single male	25	26
Single female	21	41
Total	94	108

Thus, slightly over one-half (53.4 per cent) of all of the households were classified as unstable; multi-person households with a female head were the most stable; the least stable were those in which no children were present.

Reason for Entering the Stream

The major factor responsible for the workers' migration to Belle Glade and their entry into the migrant stream appears to have been their inability to secure regular employment in their home communities. Most of the migrants originally came from rural agricultural communities. In recent years, changing agricultural practices (i.e., mechanization, crop allotments, soil banks, etc.) have caused a decrease in job opportunities for farm laborers in these areas. This, plus the continued high birth rate among rural southern Negroes, has resulted in an oversupply of agricultural workers. Some of the workers interviewed during the present project reported that they found their way into the migrant stream by responding to hired recruiters who circulate among the farms of Florida, Georgia and other southern states. Though the practice of sending "tramp trucks" into rural agricultural areas is not widespread today, some migrants who formerly held steady jobs on small farms say they were "taken in" by labor recruiters who told them of "making 25 to 30 dollars in a few hours in the bean fields."[6] Some workers reported that they heard about the "fast life" in the stream and left their home communities in search of it. Still others joined the stream to be with relatives who were already on the season.

In a study of 212 East Coast agricultural migrants, Koos[7] found that 161 (76 per cent) of the workers had entered the stream because they had lost their farm job (tenant or sharecropper) in their home state. An additional 31 workers (15 per cent) reported that they had been unable to find work in their home community when they became old enough to support themselves. Only 20 (9 per cent) of the workers had entered the stream because of their dislike of their home community or their desire to migrate from place to place. Such data tend to refute the generally held idea that migrants are in the stream because they have "itchy feet," or prefer following a nomadic way of life. The attitude of most migrants regarding their situation is one of resigned acceptance, that is, they neither strongly like nor dislike the circumstances under which they live and work. Most of the migrants simply seem to see no alternative to following the harvest; considering their limited skills and education, this is realistic.

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[6] The labor recruiters were reported to have received "five dollars a head" for each laborer delivered to the farm.

[7] Koos, op. cit., p. 23-24.

It is known that many migrants remain in the stream for long periods of time. In a study of 98 householders who went "upstream" in 1955, it was found that 42 (42 per cent) had migrated five or more times, and 24 (24 per cent) had been upstream ten or more times.[8] It is not unusual to find workers who have migrated annually for 15 to 20 years.

Life in the Stream

Life in the stream is considerably more complex that that previously experienced by most of the workers. Prior to entering the stream, many had lived on farms or in small communities in which they knew, and were known by, most of the local residents. Many had formed dependency relationships with their employers or other members of the dominant culture. As one migrant worker expressed it, "You didn't make much money when you worked for Mr.———, but he always looked out for his folks (workers)." Such statements usually indicated that prior to entering the stream their employer had "lent" them money when they were "broke," paid or "stood for" their medical bills, court fines, etc., and in most instances had provided them with food when they needed it. In addition, if the worker was known to be a reliable person, the local merchants often were willing to "carry him" (extend credit to him) until he was able to pay. While such a system may leave much to be desired, many of the migrants had left an environment in which they had felt reasonably secure.

In their present situation, the migrants seldom work for one grower for an extended period of time; often they are employed by a different grower every day of the week. Even when they work on one farm for a longer period of time, they seldom get to know the grower; in the event that they do, their relationship with him is usually quite impersonal. During the year, the migrant worker often lives in a number of communities for relatively short periods of time. Even when he returns to the same communities on successive years, he rarely becomes acquainted with many people. In contrast to his previous situation, the migrant's style of life is characterized by impersonal relationships with his employers and the communities in which he resides. In this setting he encounters numerous problems which he does not understand and which he is not prepared to meet. With the possible exception of the crew leader and a few merchants, there are few people in his environment to whom he may turn for assistance.

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[8] Northcutt, op. cit., p. 60.

Work Situation

The type of work performed by most migrant farm workers is unskilled manual labor. Though there are some special assignments which require more skills than does "stoop labor," most of the tasks consist of planting, tending, harvesting and packaging vegetables and other farm products. As previously stated, most farm migrants have had little or no non-agricultural work experience, and as changing agricultural practices have forced them off the land in their home states it is to this type of employment that they have turned.

To secure year-round employment, the farm migrants must "follow the season," i.e., they must move from place to place as the production of agricultural products demands their services. In the case of the East Coast migrant, this may involve an annual trek from southern Florida to upstate New York and return, a distance of approximately 3000 miles. While some workers seek employment in only two or three states during the year, many of them seek employment in four, five or even more states. In recent years state employment services along the route have assisted many migrants in securing employment by maintaining lists of requests for labor and data regarding the availability of labor in various areas.

Workers in the East Coast Stream usually spend six to eight months of the year in southern Florida. The fertility of the soil and the long growing season in this area often allows the farmers to grow three or more crops a year. The migrants arrive in the fall, usually in October and November, and do not begin their northward migration until late spring or early summer, commonly in May and June. While in the Lake Okeechobee region of Florida, most of the migrants work independently on a day-by-day basis. This form of employment is known as the "day haul" system. In this system the workers gather in a loading zone each morning between the hours of six and seven; here they "mill around" from truck to truck listening to the drivers quote the prices to be paid for picking vegetables during the day. At 7 o'clock a loud whistle sounds, the migrants scatter to the trucks they have chosen and leave for the day, returning from the fields in late afternoon. In this pattern, it is possible that the same migrant will be employed by a different grower each day of the week, including Sunday.

At the close of the Florida season, there are two major patterns of migrating, (1) in a labor crew and (2) "free wheeling." The labor crew is characterized by organization which involves contract negotiations between crew leaders and growers, recruitment of labor by crew leaders and providing transportation for the workers to the job site. Some crews involve as many as a hundred households, while others consist of only a few families. Some work in several states for several growers, while others may work for one farmer in one state per season. In contrast, "free wheeling" is characterized by lack of organization, less guarantee of work, more job hunting and a smaller number of workers per unit.

The U. S. Department of Labor reported that the average annual income of migrant farm workers in 1957 was $859.[9] They worked an average of 131 days a year in farm and non-farm work; thus, they earned approximately $6.50 per day worked. Information obtained during the current project, in general, supports these figures.

With earnings this low, as many of the household members as possible must work. Where several adults or older children are able to work, it is possible for the combined income to provide basic requirements fairly adequately. Where such is not the case, the families are often in dire need. During the current project, the staff reported that in a majority of the families with which they worked lack of money was a major problem. They found that most families and individuals were not financially secure to the point that adequate food, shelter and clothing could be assured throughout the year. As one staff member stated, "While we do not agree with the thesis that all migrant farm workers are always in dire financial straits, we are much less inclined to propose that few, if any, financial problems exist—they very definitely do. I feel certain that the economic situation of migrant farm workers would be viewed by other Americans with something less than envy."

The precarious nature of the migrants' economic situation seems to be influenced more by the lack of steady work available to them than by the rates of pay. Practically all of the workers are paid on an hourly basis or by "piece work" (i.e., a given amount for each unit of produce harvested). In either case, there is no assurance of steady employment, and there is no income when work is not available. The regularity of the migrants' employment is influenced by such multiple factors as weather, market supply and demand, the buying habits of the public and the labor supply.

In recent years there has been an abundance of laborers most of the time. As migrants view it, "Farm work ain't what it used to be—they's too many people in the field now." One of the workers interviewed commented, "It's getting to the place that they's a worker for every bean."

Living Arrangements[10]

During the year it is necessary for most migrants to secure housing in two or more states. In some instances, on-the-farm housing is provided by the grower; in others it is necessary for the migrant to secure his own. During their stay in Florida, it is estimated that approximately half of the workers arrange for their own housing in in towns and villages adjacent to the farming areas; the remainder use on-the-farm housing or labor camps. While working upstream, practically all of the migrants live in labor camps and on-the-farm housing.

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[9] U. S. Department of Labor, *Farm Labor Fact Book*, Washington: Government Printing Office, 1959. P. 193

[10] For a more detailed description of migrant housing, see Chapter III.

In the Belle Glade area, some of the workers live in the Okeechobee Housing Camp which was built by the War Foods Administration; others live in rental units in the downtown area; and still others live in housing provided by the growers. At the end of the season in Florida, some of the migrants, especially those living in the Okeechobee Camp, arrange to keep their housing in Belle Glade during the summer months while they are working upstream; others give up their housing each spring and find different quarters when they return in the fall. The storage of household and personal articles that cannot be taken upstream is often a problem for workers who do not maintain their Florida housing during the summer months. An earlier study[11] revealed that approximately 40 per cent of the workers stored some items in Belle Glade when they went upstream. Of these, approximately one-half paid rent for storage space, with the remainder leaving their belongings in the homes of friends or relatives.

While in Florida a majority of the migrants live in family units. As they move upstream during the summer months, some move as complete families, while others leave some members of the family behind. Often a woman with small children will remain in Florida while her husband goes upstream. In other instances, the small children may be left with relatives in Florida or their home state while both parents make the northward trek. In some cases, adults who do not migrate will allow their older children to go upstream with friends or relatives. Housing conditions elsewhere are often such that the workers report that it is difficult to live as a family unit even when they take all of the members along.

Child Care and Education

The migrant mother must work and the need for child care facilities is great. Because of low income, she usually is unable to pay a high rate for child care. The lack of low cost child care facilities appears to be a problem throughout the stream. While some private and church-supported facilities are available, the number of children they can accommodate is small, and the prices which they must charge are often more than migrants can afford. Koos[12] noted that the cost to the migrant, even in those facilities where there is a subsidy, is usually in the neighborhood of 75 cents per day per child, a price which a mother with two or three small children cannot afford. As a result, day care is often given for a minimum fee by old women who are no longer able to work in the fields; the amount of supervision provided in such cases is negligible, and the quality of care leaves much to be desired.

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[11] Northcutt, op. cit., p. 52.
[12] Koos, op. cit., p. 40.

Where such conditions exist, the alternatives for the migrant mother are either to take the small children to the field or leave them with an older child if one is available. Neither of these is satisfactory. School officials report that the latter practice helps to contribute to absenteeism among migrant children.

For those workers concerned with keeping their children in school, the periodic migration involved in following the season creates an educational problem. A few families are so concerned over their children's education that they will leave New York State before the end of the season in order to have their children enter school on time in Florida. (Such a practice usually means that they will have little or no work for some weeks.) Others send their children back to Florida at the beginning of the school term to live with relatives or friends until their return. A vast majority of the workers, however, remain upstream as long as work is available; this means that their children will be late in entering the Florida school term. Some of the migrants enroll their children in school only when they "get around to it," and still others enroll them only when the schools make special efforts to get them enrolled.

In an earlier study of a labor crew from the Belle Glade area,[13] 81 (70 per cent) of the 115 children in the 6-18 year age group were reported as being enrolled in school. On checking the school records, however, 24 (29.8 per cent) reported as enrolled were unknown to any of the schools in the area. Of the 57 found enrolled, four had withdrawn before the end of the term, although their households had not left the community. Data on the time of entry into the schools were available on 52 of the 57 students. Only seven (13.5 per cent) of the 52 students had entered at the beginning of the fall term. Seventeen (32.7 per cent) had entered in October, 18 (34.6 per cent) in November, and 10 (19.2 per cent) after December 1. In addition to late enrollment, there is a considerable amount of absenteeism. Table 3 shows the number of absences of 53 of the children between January 1, 1955, and the close of school.[14] During this period, school was in session a total of 109 days. The average number of absences per child for the entire group was eight days during this period.

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[13] Northcutt, op. cit., p. 64-67.

[14] Four attendance records were not available.

TABLE 3

Number of Absences of 53 Migrant Children As Reported By School Officials, Belle Glade, Florida
January 1 - Close of Term 1955

Number of Absences	Number of Pupils	Percentage
Total	53	100.0
None	16	30.2
1-5	21	39.6
6-11	6	11.3
12-17	2	3.8
18-23	1	1.9
24-29	5	9.4
30 or more*	2	3.8

* One child was absent 64 days, another 48 days.

Of the 57 children enrolled in school, 22 (38.6 per cent) were retarded two or more years. No information is available regarding the academic achievements of those who were not enrolled.

Legal Residence

Because of their frequent migration, agricultural migrants have been described as "residents of nowhere."[15] Among 236 adult migrants (21 years of age or older) studied by Koos, only 19 (8 per cent) could meet the residence requirements for voting, and only 11 of these could have met the residence requirement for any form of public assistance.

Usually, lack of legal residence does not present obstacles to migrants in obtaining public health services or in placing their children in public schools. It is in the area of qualifying for welfare assistance that migrants most frequently encounter difficulty. Some communities have developed committees to assist non-residents in times of emergency.

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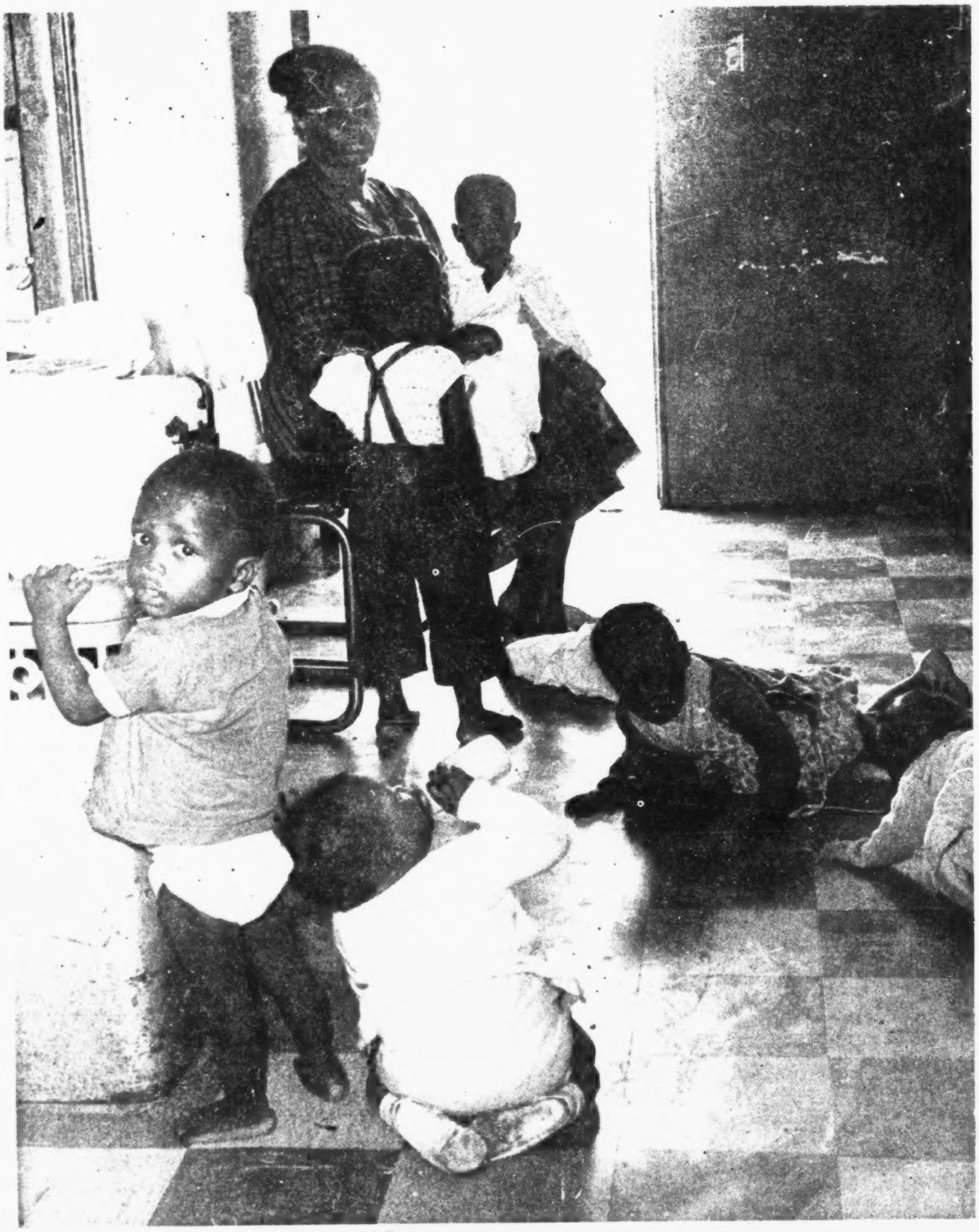
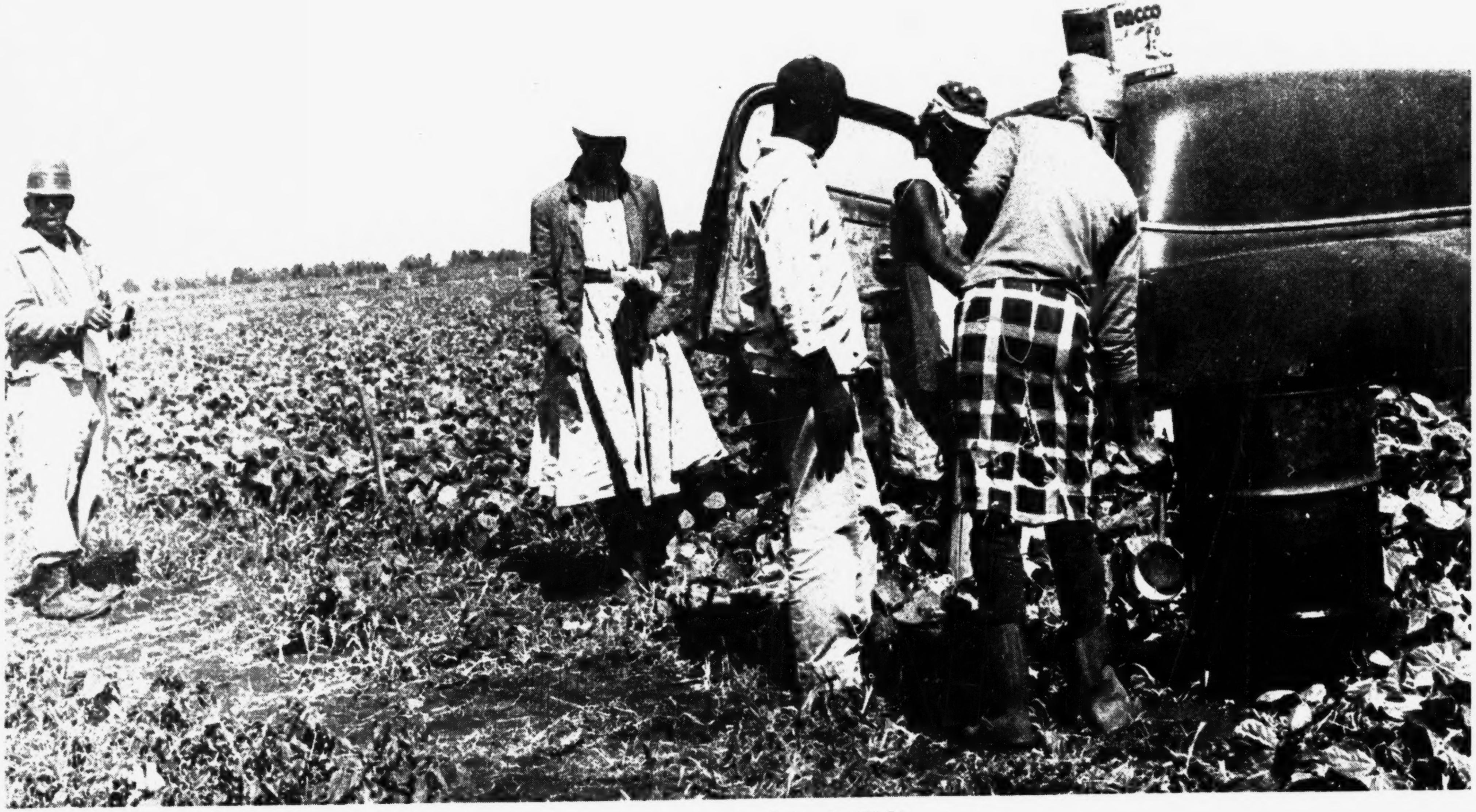
[15] Kons, op. cit., p. 20.

A Private Child Care Center in the Migrant Area



Private Child Care in Belle Glade



Lunch in the Field

CHAPTER THREE

MIGRANTS AND THEIR PHYSICAL ENVIRONMENT

Housing

Farm migrants returning to western Palm Beach County early in the farming season have a wide selection of living places. Some migrants choose to live on farms in rent-free housing and to work for one farmer during the farming season; other migrants prefer to live in rental housing within municipalities and work day haul, i.e., to seek work daily among several employers.

In the two geographic areas where project activities were concentrated, the people lived in crowded conditions. Living quarters were small; households large. More than half of the households lived in one room per household; slightly less than 90 per cent of the households lived in not more than two rooms per household; households having three or more rooms constituted slightly more than 10 per cent of the households. Generally, there was 150-200 square feet of floor space per room. Table 4 shows the distribution.

TABLE 4

Living Arrangements, 346 Negro Households, Palm Beach County, Florida, 1956-60

Number Rooms	Number Households	Per Cent of Total Households	Number Persons in Households	Per Cent of Total Persons	Mean Number Persons in Household
Total	346	100.0	1851	100.0	5.3
1	198	57.2	842	45.5	4.2
2	107	30.9	732	39.5	6.8
3	23	6.6	157	8.5	6.8
4	8	2.3	55	3.0	6.9
5	3	.9	24	1.3	6.0
6	3	.9	18	1.0	6.0
7	1	.3	2	.1	2.0
8	3	.9	21	1.1	7.0

The mean weekly rent for a single room was $5.83, according to information reported by 354 households in the project areas. The mean number of rooms per household was 1.5, and the mean weekly rent per household was $7.55, though more than half of the households lived in one room per household. Table 5 illustrates weekly rent distribution.

TABLE 5

Amount of Weekly Rent Paid by 354 Negro Households, Palm Beach County, Florida, 1956-60

Amount of Weekly Rent	Number and Per Cent of Households	
	Number of Households	Per Cent of Households
Total	354	100.0
$16.00	3	.9
$11.00 - 15.00	60	16.9
$ 6.00 - 10.00	194	54.8
$ 1.00 - 5.00	96	27.1
$ 0	1	.3

In a ninety square mile area of western Palm Beach County, the project sanitarian inspected 320 establishments which house migrant farm workers. The remainder of this chapter presents the observations made concerning the environment of migrants in western Palm Beach County. It should be noted that these observations were made *prior* to the advent of accelerated governmental activities designed to improve housing conditions of farm migrants in Florida.[1]

Resident supervisors, landladies, managers or other persons designated to perform supervisory functions were found in 244 (76.3 per cent) of the establishments. No persons were designated to perform supervisory functions in 76 (23.7 per cent) of the establishments. The supervised establishments had 17 defective items per establishment; the non-supervised establishments had 30 defective items per establishment.

A satisfactory domestic environment requires that the basic structure protect the occupants from the elements and be of reasonably sound construction. Protection from the elements was inadequate in 123 establishments surveyed; migrants have few means at hand to remedy defects. Newspapers stuffed into the cracks in walls and floors was one remedy. It was not unusual to find interiors covered with newspapers or lined with pasteboard cartons. Color photographs from magazines, advertising posters and pictures with religious themes served as functional decorations. The safety and public health implications are that situations such as these sometimes present serious fire hazards and provide insect and rodent harborage.

Without exception, there was clothing on wire hangers somewhere in each dwelling unit. Most migrants who travel annually have some sort of luggage—a suitcase, a foot locker or both. Provisions for storage or closet space were found in 16.6 per cent of the establishments. Walls which otherwise may have been undamaged were marred by migrants' attempts to provide closet or storage facilities by nailing board or broom handles across corners of rooms; lengths of pipe were sometimes driven into this position. These remedies were not always accomplished with care or permanency.

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[1] Disastrous freezing weather in the winter of 1957-58 focused state, county and local attention on the "plight of the migrants." Public funds were immediately disbursed to assist in coping with the emergency; Florida's biennial legislature in 1959 enacted legislation setting standards for migrant labor camps.

The migrants use multiple extension cords strung the shortest distance from sources of electricity; many splice directly into the nearest house wiring. Some of the older establishments have electric wiring which is now substandard. More than a hundred pennies were found behind screw-in fuses. A wise trend in migrant housing currently under construction is the use of double electrical outlets scattered throughout the unit and the protection of house wiring by automatic circuit breakers. Newer housing, for the most part, supplies electric current individually metered to the units, but rarely are 220 volt outlets installed. Some migrants, at the beginning of each season, are unable to pay a deposit of $10 or $20 for electric service.

The majority of migrant housing establishments (84.4 per cent) provide adequate fire egress. Although inadequate fire escapes are serious situations where they occur, most migrant housing is at ground level. Steps and stairs should be solid, level and unobstructed. Hazardous steps and/or stairs were found in 45.9 per cent of the establishments. Apparently management failed to maintain stairs and steps which were frequently obstructed by migrants.

Conversations with migrants indicated lack of knowledge in the use of common fire extinguishers. Some recognized the soda-acid extinguisher but did not know of its prohibited use on electrical or oil fires. Few occupants of an establishment knew the location of the master power cut-off switch or that the switch should be opened before attempting to fight a fire. The majority were concerned only for the loss of life—not property. "Drunks" burning up mattresses in the same building or exploding kerosene stoves were their greatest fears concerning fire.

In view of the nature of fires in migrant housing and the migrants' general knowledge of fire fighting, covered sand-filled drums painted red and labeled "Fire," even with their limitations, appear to be the safest for migrants to use.

Water, Waste and Garbage

In certain sections of the area, ground water is chemically unsatisfactory for domestic use. One of the sections contains 11 camps where water for domestic use is transported by various means, few of which protect water adequately. Carrier and storage facilities, in these instances, subject potable water to bacteriological contamination.

Some establishments have two water systems. One system supplies drinking and cooking water; the other system, usually a pitcher pump or a shallow well, supplies water for laundry and other purposes. Apparently, migrants consider both water supplies suitable for drinking purposes, since they drink from either supply.

Pumps, storage or pressure tanks, valves and spigots or faucets must be in good repair to deliver a satisfactory water supply. One or more of these items were defective in 102 (31.9 per cent) establishments.

Hot water was furnished in 83 (25.9 per cent) of the establishments. In 228 of the 237 establishments not furnishing hot water, some tenants were cooking or heating water on unsafe appliances in their sleeping rooms.

The Belle Glade municipal sewer system was completed a short time following the survey. By January 1960, the majority of establishments reported as having septic tanks were connected to the sewer system.

Table 6 shows methods of sewage disposal and their conditions at the time of the survey.

TABLE 6

Distribution and Conditions of Excreta Disposal Facilities, 320 Migrant Labor Housing Establishments, Palm Beach County, Florida, 1958-59

Method of Excreta Disposal	Need Repair		Functioning Properly		Total	
	Number	Per Cent	Number	Per Cent	Number	Per Cent
Total	193	60.3	127	39.7	320	100.0
Sewer Systems*	1	.3	4	1.3	5	1.6
Septic Tank(s) only	164	51.3	119	37.2	283	88.4
Privy(ies) only	26	8.1	3	.9	29	9.1
Septic Tank(s) and Privies	2	.6	1	.3	3	.9

*Primary Treatment, Imhoff

Few establishments (11.6 per cent) reserved toilets and baths for the exclusive use of each household. A practice in establishments providing the central, shared or gang toilets was the use of receptacles called "slop jars" primarily for nighttime use. The slop jars were usually kept in the kitchen area and often were also used for garbage and other household waste. The problem arises as to disposal of slop-jar contents when body waste is mixed with other household waste. Water flush closets do not function long as a disposal means for both.[2] To facilitate the passage of solids through the sewage system, the occupants broke the traps in many porcelain toilet fixtures. This practice results in clogged plumbing, allowing sewer gas to vent back into the toilet room. In the same establishments the garbage collection and storage point was cen-

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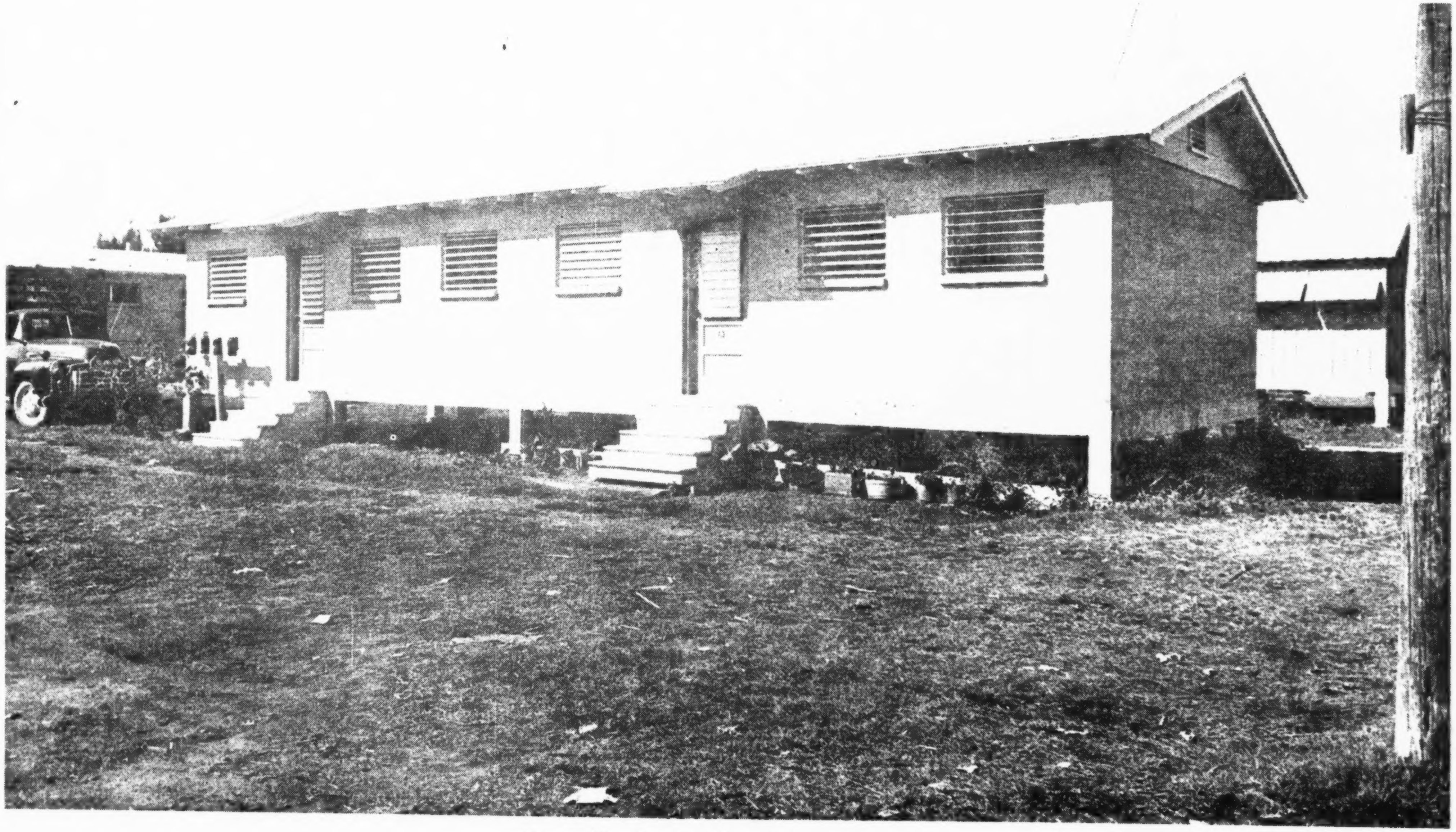
[2] Mixed waste disposal was not as acute a problem where privies were provided.



Newer Housing in Okeechobee Project

tralized and, generally, more remote than the toilets. Fear of walking through poorly lighted areas, poor sanitary maintenance, congestion and lack of privacy were reasons given by the tenants to explain their use of slop jars. Part of the poor sanitary maintenance was attributed by tenants to activities of unsupervised children.

A review of the Florida State Sanitary Code, the recommendations of the President's Committee on Migratory Labor and the requirements of the Florida Hotel and Restaurant Commission indicates that a ratio of one toilet fixture and one bathing facility per 15 persons of each sex is a minimum requirement. More than two-thirds (71.9 per cent) of the establishments had adequate numbers of toilet facilities. Less than half (49.4 per cent) of the establishments had adequate numbers of bathing facilities.

Toilet and bath facilities were shared by two or more families in 88.5 per cent of the establishments. Migrants seem to prefer bathing in a washtub in the privacy of their rooms to bathing in shared or group facilities. Cold water showers only were provided in 74.1 per cent of the establishments. Heating was inadequate in 78.5 per cent of the bath and toilet areas and rarely were clothing hooks or benches provided. The use of highly toxic pesticides in agriculture makes it even more important that adequate bathing facilities be provided. Perhaps these observations indicate the importance of considering comfort and convenience in designing establishments to house migrant farm workers.

Mud tracked into the living quarters is one the problems faced by migrant households. Children who go in and out of the dwelling units throughout the day magnify the problem. Sinks to catch splash water at taps where household use water was drawn were provided in 31.6 per cent of the establishments. Adequate sinks for liquid kitchen waste disposal were provided in 18.6 per cent; laundry waste disposal was adequately provided for in 11.9 per cent. Storm water drainage from yards and common use areas was satisfactory in 68.1 per cent.

Liquid kitchen waste (dishwater, etc.) from migrant households contained considerable solid food particles, i.e., beans, rice, meat scraps, etc. Migrant housing operators who furnished sinks for kitchen waste disposal frequently complained that the sink plumbing was "always stopped up." Preventive measures were methods of prescreening the waste. Where the yard area and ground water table permitted, some of the on-the-farm camps used an effective "plumbingless sink."[3] The plumbingless sink requires a screen and garbage receptacle nearby for frequent cleaning of the screens.

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[3] A plumbingless sink is a stack of three concrete "O" blocks mortared together onto a concrete slab which covers a rock-filled hole. Between the top of the stack and a fourth loose block is a suitable piece of screen wire (16-inch mesh). Quicklime to speed oxidation is liberally applied when the top block and screen are removed for cleaning.

Splash water at water supply points can be controlled effectively in farm camps, where soil has suitable percolation characteristics, by planting under the spigot a drum (usually 55 gal.) opened at top and bottom, filled with coarse rock.

Facilities for washing and drying clothes were absent in 86.3 per cent of the establishments. Seeking a substitute for laundry facilities, some migrants remove spray heads from shower facilities in order to obtain a direct stream of water. Clothes are dried wherever lines can be strung and where they may be watched for protection against theft. In crowded living areas, space near electrical outlets is not always readily available for ironing. Clothing must be protected against smoke from kerosene cook stoves.

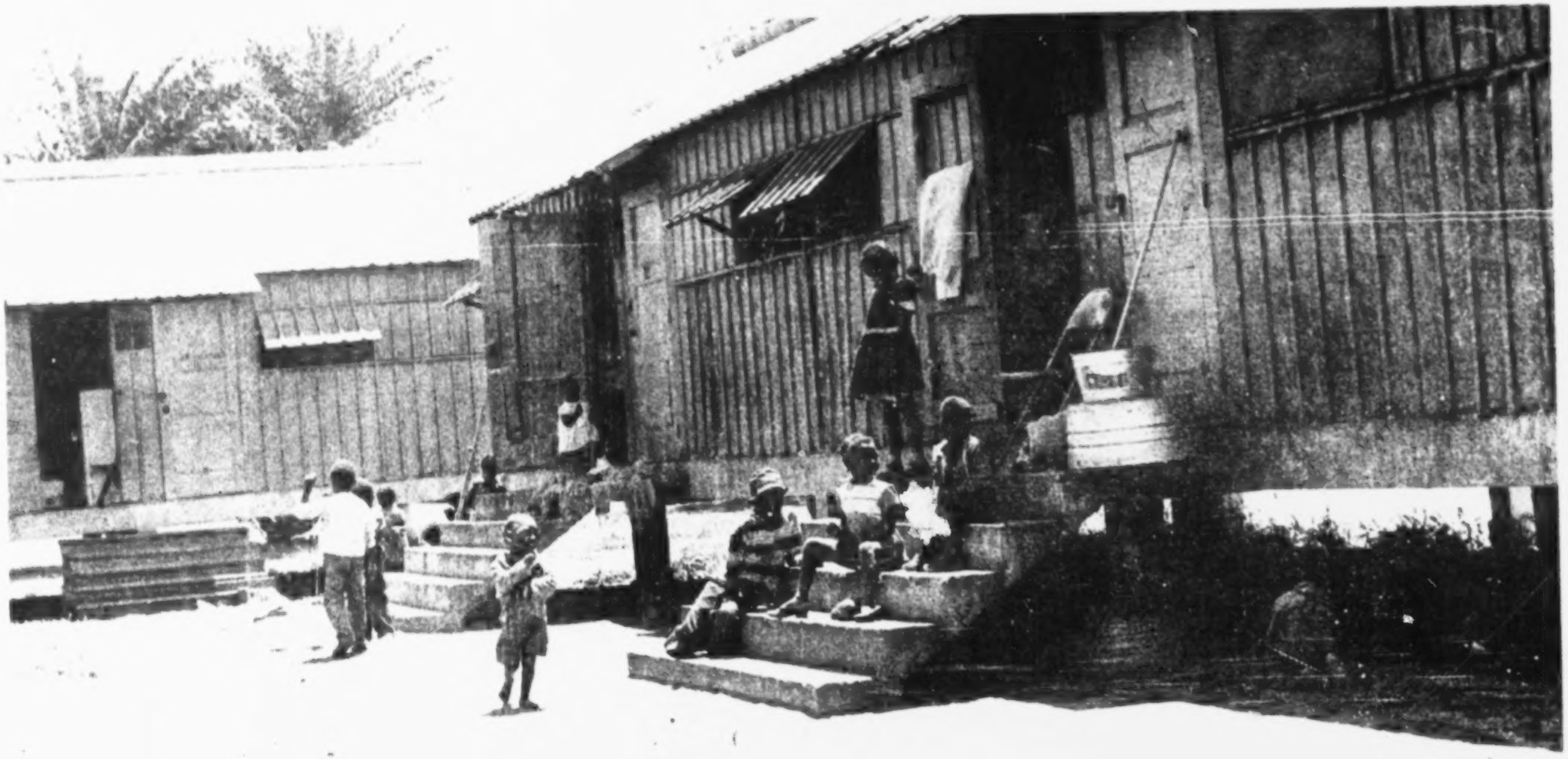
Fewer garbage problems occurred in the establishments where each garbage can was identified as being the responsibility of a specific household, as opposed to establishments having central garbage storage facilities. In the former, offensive practices could be more easily corrected than in the latter where central storage facilities were not the responsibility of any specific household. Where central storage facilities were used, the removal of garbage from dwellings to storage areas was generally delegated to youngsters in the households when dumping areas were not near the dwellings. Garbage conditions were usually unsatisfactory where garbage storage facilities were located.

When migrants leave to "go up the road," possessions which cannot be transported or are not worth taking, e.g., stuffed furniture, soiled bedding, automobiles which don't operate, are abandoned or stored, creating nesting material for rodents and breeding places for insects. Food such as cornmeal, dried beans, sugar, etc., is left on open shelves easily accessible to vermin. Migrant households make little effort to control rodents or insects.

Refrigeration, Heating and Ventilation

Most of the housing units had no refrigeration facilities. Unsatisfactory refrigeration conditions, including the units having no refrigeration facilities, occurred in 85.3 per cent of the establishments. Generally, migrants do not accumulate possessions which are not readily portable. The presence of electric refrigerators in homes of year-round residents has led to a reduction of ice deliveries in rural areas. Where ice deliveries are made, the use of portable light-weight block ice chests may be helpful to migrants in overcoming their refrigeration problems.

Migrant housing establishments are not wired adequately for electric heaters, or electric heaters are prohibited because of operating costs or by management. Natural gas is not available in the area; bottled gas required installation fees and cash deposits on the tanks. The only economical cooking and heating fuel available to



"Tin Shelter Housing" in Okeechobee Project

migrants is kerosene. During the periods of cooler weather most households were using their kerosene cookstoves to heat their units. Most of these kerosene heaters and cookstoves in the establishments are open-flame and unvented appliances.

As migrant households adjust to their physical environment, they tend to seek, devise or adopt the simplest and most expedient solutions to immediate problems at hand. The modifications and adjustments which they make in their living quarters may not always be in accord with the wishes of the owners of the dwelling units or in accord with prevailing building, plumbing, electrical or sanitary codes or regulations. Some of the abuses of housing and related facilities which have been attributed to deliberate destruction on the part of migrant households are probably a result of the migrants' attempts to make their environment more functional. This observation indicates the existence of conflict between the migrants' concepts of that which is necessary and desirable for the maintenance of a satisfactory domestic environment and the concepts held by persons other than migrant farm workers.

CHAPTER IV

HEALTH AND HEALTH CARE OF MIGRANTS

OBSERVATIONS OF the health and health care of migrants were made in the Belle Glade Health Center and the community it serves. The Center provides a comfortable and well-equipped clinic, office and waiting room space. It is the focus for public health service to a total population of some 25,000 of which a majority are Negro. Attention is limited here to this racial component.

It has been indicated that in the town of Belle Glade the migratory agricultural laborers intermingle with more permanent Negro residents. In one family some may work on the season while others remain continuously in the county. The same person may move with the season one year and remain in a fixed location the next. Despite the particular interest in the migratory agricultural laborers, the project team of necessity gave attention to the Negro residents of the study area. Only on the basis of history of movements of the preceding year or plans to work on the season during the ensuing summer and fall could the Negro clients from the town be divided into migrant and non-migrant groups. By contrast, those living on the farm in labor camps were predominantly migrants.

Data recorded in this chapter were obtained while giving health services in the clinics, hospitals and homes. Some of the data are based upon the examination of apparently healthy families who attended family clinics by invitation and appointment. The data obtained in the clinics were supplemented by special studies as here reported.

General Physical Status

Complete physical examinations were given to 862 apparently healthy men, women and children invited to the family clinics. These proved to be approximately equally divided between migrants and non-migrants. The recorded abnormalities are shown in Table 7. Those most frequently encountered were nutritional problems, dental problems, other abnormalities in the mouth or throat and disorders of the genitourinary system, each of these occurring in from 10 to over 20 per cent of those observed.

Serological tests for syphilis were made on the 245 adults attending the clinics; only five (2.0 per cent) were found to be positive. No marked difference was found in the prevalence of positive serologicals between migrants and non-migrants. In addition Papanicolaou smears were taken on 85 of the migrant females 21 years of age and over and on 65 of the non-migrant females in this age group. Six (7.1 per cent) of the migrant women and two (3.1 per cent) of the non-migrant women were found to have positive smears.

In general, there was no marked difference in the findings in migrants and non-migrants. The suggestive observations were that nutritional problems were more common among the migrants and genitourinary disorders more common among the non-migrants.

TABLE 7

Distribution of Physical Abnormalities among 862 Negro Patients by Migration Status, Migrant Project Family Clinics, Belle Glade, Florida, 1957-59

ABNORMALITY, Site or Nature	Number and Percentage Distribution of Abnormalities by Migration Status			
	MIGRANT		NON-MIGRANT	
	Number	Percentage Distribution	Number	Percentage Distribution
Total Patients	439	—	423	—
Head, Face, Neck, Scalp	33	7.5	46	10.9
Nose	9	2.0	9	2.1
Sinuses	1	.2	5	1.2
Mouth and Throat	85	19.4	61	14.4
Ears - General	36	8.2	20	4.7
Lungs and Chest	19	4.3	10	2.4
Heart	31	7.1	38	9.0
Vascular System	24	5.5	17	4.0
Abdomen and Viscera	40	9.1	46	10.9
Anus and Rectum	9	2.1	9	2.1
Umbilical Hernia	39	8.9	32	7.6
Endocrine System	5	1.1	11	2.6
G-U System	43	9.8	55	13.0
Upper Extremities	9	2.1	14	3.3
Feet	13	3.0	9	2.1
Lower Extremities	31	7.1	27	6.4
Spine, Other Musculoskeletal	12	2.7	13	3.1
Body Marks, Scars, Tattoos	24	5.5	17	4.0
Skin Lymphatics	41	9.3	28	6.6
Neurologic	5	1.1	9	2.1
Urine	14	3.2	19	4.5
Nutritional Problem	97	22.1	57	13.5

Maternal Health

Problems in maternal health and maternity care among the project population are enmeshed in a number of complicating factors which make solutions difficult to reach. Among the group receiving maternity services at the Belle Glade Health Center, there are three predominant characteristics: (1) frequent pregnancies; (2) lack of adequate prenatal care; (3) insufficient funds to afford private medical care.

Observations by physicians and public health nurses concerning the health characteristics of pregnant women in the project population indicate the following: (1) low hemoglobin; (2) extremes of blood pressure; (3) low incidence of positive serology (syphilis).

According to the records of 719 Negro maternity patients seen at the Belle Glade Health Center, 1957-60, the mean number of pregnancies per patient was 4.8. Further, a review of 525 records[1] showed that 48.8 per cent of the patients became pregnant again within 12 months following delivery; cumulatively, 78.1 per cent of the 525 patients were again pregnant within 24 months following delivery. Only 21.9 per cent of the group had at least two years between pregnancies.

The records of 730 Negro maternity patients indicate that the mean number of living children per patient was 3.2. Excluding 143 patients who reported having no living children, the mean was 3.8 living children per patient.

Information from 693 records of Negro maternity patients showed that most of the women reported for prenatal care during the second trimester of pregnancy, 24.4 per cent of the 693 patients reporting for care during the sixth month of pregnancy. By trimesters, 7.8 per cent reported during the first; 56.8 per cent, the second; 35.2 per cent, the third.

From July 1, 1958, through June 30, 1959, every Negro maternity patient who delivered at the Belle Glade Hospital was interviewed to determine certain information pertaining to their pregnancies. A total of 317 interviews were conducted, and the data show no difference in the number of visits for prenatal care between migrant and non-migrant women. The mean number of visits for migrant women was 4.4; for non-migrant women, 4.8. Seven (2.2 per cent) of the women reported receiving no prenatal care.

Nutritional Status

Although detailed physical examinations for signs of good or poor nutritional status were not conducted, some information was obtained through the general physical examinations. Some of the children showed evidence of scurvy, rickets, nutritional anemias and marasmus. One case of kwashiorkor a serious protein deficiency disease, was found. This disease occurs primarily in underprivileged regions, both within and without the tropics, and has been diagnosed only in rare instances in the United States.[2] The case referred to here occurred in a female child three years of age who responded to treatment over a period of several months.

Heights and weights of patients attending the clinics were recorded. A high percentage of the findings for 388 children, when

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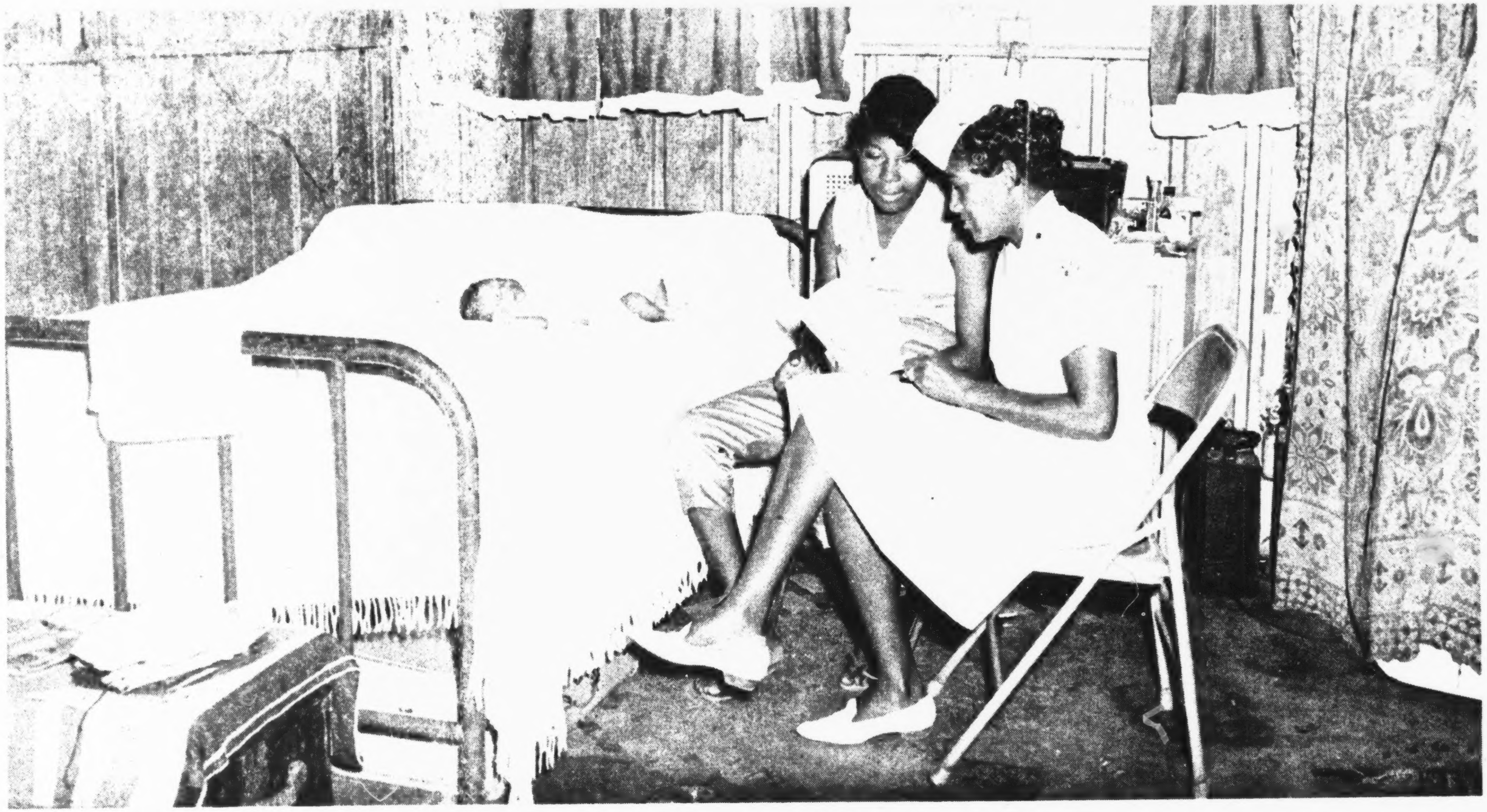
[1] Some records were incomplete because of migration and other factors.

[2] M. G. Wohl and R. S. Goodhart, *Modern Nutrition in Health and Disease*, Philadelphia: Lea and Febiger, 1955, p. 607



Migrant Mother Receiving Child Care Instructions plotted on the Stewart Grid,[3] fell in the lower percentiles, this indicating a need for more detailed study of the growth of migrant children.

A dietary study was conducted among a group of 35 families in the Okeechobee Project to determine whether the food intake was adequate in terms of the *Recommended Allowances* of the National Research Council. Records of a week's food intake for each family yielded the following information:

Milk and milk products — not adequate
Green and yellow vegetables — not adequate
Citrus and other fruits — not adequate
Meats and meat alternates — adequate (borderline)
Starches, fats and sweets — above adequacy

These data were consistent with information obtained from a three-day dietary evaluation of 37 fifth-grade pupils in the Okeechobee (Project) Elementary School. Results of the survey are shown in Table 8 on page 36.

Dietary Practices

Lack of space and equipment in the migrant quarters limited the possibilities in the preparation of food. Most families used two-burner oil stoves, one or two pots and a frying pan for cooking purposes. Refrigeration was not generally available though some families had ice boxes. Families rarely ate together at a table. Usually each person served himself and ate while sitting on a bed or on the doorstep.

The customary diet pattern included a heavy early-morning meal; a snack lunch which was usually purchased in the fields; an evening meal consisting of left-overs from breakfast. The following is a fairly typical example of a daily diet:

Breakfast	Lunch (in field)	Supper
Fried Fish	Meat Sandwich	Fried Fish
Grits	Carbonated Drink	Grits
Collards		Flour Bread
Flour Bread		Syrup
Syrup		

Meats which were purchased frequently included: chicken, pork chops, pig tails, pig feet, pig ears, neckbones, sausage, ground beef and stew beef. Fish comprise an important part of the diet, and fishing is a simple matter in the Belle Glade area with its network of fresh-water canals.

Meals were served at various times, depending upon whether or not mothers were working. When mothers were not working, evening meals were usually served around 4 p.m. Some families seldom cooked. In such cases, meals usually consisted of luncheon meats, cheese, canned beans, sweet rolls, bread and soft drinks.

Some school children ate nothing between breakfast and supper; other children returned home at noon and ate breakfast left-overs.

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[3] Charts providing standards of reference for body weight and height for boys and girls, based on data obtained in Boston, Massachusetts, area on boys and girls of North European ancestry. Distribution of measurements expressed in percentiles.

Expectant Mother and her Infant Receiving Health Services at Belle Glade Health Center

Vegetables were usually available but were not used as often as they could have been, even though women in the project areas commonly indicated that they like vegetables and recognize their nutritive value. Year-round gardens were maintained by some families. Vegetables were also available in the fields to workers who wished to carry them home. Traditionally, vegetable fields are abandoned after several pickings, and the vegetables which remain are free to anyone who may wish to pick them. Fruits were neither as abundant nor as available as vegetables; usually they had to be purchased and, consequently, were not widely used.

Breads and baking items made up much of the diet. However, home baking was not prevalent. Sweetened, powdered drinks were used extensively by children and adults; milk was bought primarily for infants and small children. Considered as an expensive item, milk was drunk only occasionally by adults; skim milk powder was unknown to many families.

Infants were usually fed from bottles, sometimes in combination with breast feeding. Mothers tend to feed infants increasing amounts of milk, even up to one-half gallon per day, instead of adding solid foods along with the formula. As a result, solid foods were often rejected by infants when finally offered. A few mothers gave baby foods to infants, but the selection did not usually include foods high in nutritive value.

Food-buying practices of the families varied with the availability of storage facilities and money. Where refrigeration facilities were not available, food was purchased daily to avoid spoilage in the subtropical Florida climate. Some grocery stores in Belle Glade opened at 5 a.m. for the convenience of the farm workers. When no money was available, some families lived on fish from the canals and vegetables from the abandoned fields. In some cases, grocery store managers extended credit to farm workers.

Many families were eager for assistance in planning food budgets. Information on the use of dried skim milk powder was used as one example of how to increase food value for the entire family. Demonstrations and "tasting parties"[4] were used to teach families about skim milk powder; generally, the response to these efforts was favorable. Help was offered in learning to buy from a planned list, but this method was not accepted to any great extent.

Group instruction in nutrition was attempted with those attending prenatal clinics. No real success was achieved. Many women found it necessary to bring small children with them to these clinics, and attention was always divided. However, they enjoyed tasting parties and were quite willing to taste almost everything offered to them. Ideas regarding "craving" of items during pregnancy are common among the group. Starch, chalk and flour are consumed frequently by patients who expressed belief that the body craves these materials because of a need.

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[4] Samples of foods unfamiliar to the group are tasted.

TABLE 8

Distribution of Food Intake in Relation to Recommended Dietary Allowances of the National Research Council, 5th Grade Students, Okeechobee Elementary School, Belle Glade, Florida, 1959

Food Group	Per cent Receiving Recommended Allowance	Per cent Receiving Less than One-half Recommended Allowance	Per cent Receiving None of Recommended Allowance
Milk	5	84	11
Green and Yellow Vegetables	27	16	57
Citrus Fruits and Tomatoes	11	57	32
Other Fruits and Vegetables	59	30	11
Meat, Fish and Poultry	62	38	0
Meat Alternates	89	11	0
Breads and Cereals	100	0	0

Dental Health

Dental defects were observed commonly in children and adults alike. Most frequently seen were caries, pyorrhea and abscesses. In 1959, a dental survey was conducted by the Florida State Board of Health, Bureau of Dental Health, among 138 members of the project population group. Results of the survey are shown in Table 9 on page 37.

Communicable Diseases

Information available in Palm Beach County does not indicate a significant difference in the prevalence of communicable diseases among agricultural migrants as compared with people of the same socio-economic groups who do not migrate. These diseases do constitute a serious problem among agricultural migrants, causing a great deal of disability, significant mortality, associated economic loss and other problems. Case finding and follow-up are difficult among migrant workers because of their mobility.

During the course of the project, a chest X ray survey, tuberculin testing and blood test surveys were conducted among migrant farm workers. Although follow-up proved difficult due to mobility of the workers, a number of cases of these were brought to treatment.

Tuberculosis

Tables 10, 11 and 12 show the results of three chest X ray surveys. Of a total of 13,067 X rays taken in these surveys, 13 new cases of tuberculosis were found. One previously known case was found to be active. Twelve patients were hospitalized. Several cases of other types of pathology were also discovered.

During the course of the project, a total of 84 Negroes from the Belle Glade area were admitted to tuberculosis hospitals for treatment.

TABLE 9

Dental Health Status, 138 Negroes, Belle Glade, Florida, 1959
By Age Group

		Clinical Findings								
Number of Persons by Age Group		Permanent Teeth				Deciduous Teeth			Diseased or Abnormal Conditions of Oral Tissue		
Age Group	Number Persons	Decayed	Missing	Filled	Total DMF	Decayed	Filled	Total DF	Lip	Gum	Tongu
Totals	138	466	22	174	662	278	2	280	42	49	80
1 - 5	20	1	0	0	1	36	0	36	2	2	10
6 - 10	62	126	5	6	137	220	2	222	12	16	26
11 - 15	30	161	0	16	177	22	0	22	10	8	22
16 - 20	3	28	0	19	47	—	—	—	2	3	3
21 - 25	0	0	0	0	0	—	—	—	0	0	0
26 - 30	4	37	3	22	62	—	—	—	3	4	3
31 - 35	9	65	5	31	101	—	—	—	6	7	7
36 - 40	2	6	3	8	17	—	—	—	2	2	2
Over 40	8	42	6	72	128	—	—	—	5	7	7

In 1958-59, 1462 Negro school children in Belle Glade were given tuberculin tests using the intradermal method with a dosage of 0.0001 mg. PPD. Two hundred and two (13.8 per cent) reacted positively to the tests. One hundred ninety-eight (93.06 per cent) of the reactors were X-rayed. The total number of reported contacts was 893; 408 were adults, 485 were children. Three hundred and thirty-two (81.4 per cent) of the adult contacts were X-rayed; 330 (68.0 per cent) of the child contacts were tuberculin tested. Results of the follow-up among reactors and contacts revealed four cases of primary tuberculosis.

TABLE 10

Results of Chest X-ray Surveys on Migrant Agricultural Workers, Palm Beach County, Florida, 1958, 1959, 1961.

Results	YEAR 1958	1959	1961
Total Films Taken	2067	7084	3916
Definite or Suspicious Tuberculosis	63	150	42
Follow-up Completed	29	109	26
New Cases of Tuberculosis	4	5	4
Old Cases of Tuberculosis	3	10	5
Cardiovascular Disease	3	3	0
Other Pathology	7	31	5
Cases of Tuberculosis Hospitalized	3	5	4

TABLE 11

New Cases of Tuberculosis by Stage and Activity, Migrant Labor Chest X-ray (70 mm) Screening Surveys, Palm Beach County, Florida, 1958, 1959, 1961

Stage and Activity	YEAR 1958	1959	1961
Total Cases	4	5	4
Primary	0	0	0
Minimal	1	0	0
Moderately Advanced	2	2	2
Far Advanced	1	3	2
Unknown	0	0	0
Total	4	5	4
Active	1	3	4
Inactive	0	0	0
Probably Active	0	2	0
Probably Inactive	3	0	0
Total	4	5	4

TABLE 12

Old Cases of Tuberculosis by Stage and Activity, Migrant Labor Chest X-ray (70 mm) Screening Surveys, Palm Beach County, Florida, 1958, 1959, 1961

	YEAR		
Stage and Activity	1958	1959	1961
Total Cases	3	10	5
Primary	0	0	0
Minimal	0	4	4
Moderately Advanced	2	4	0
Far Advanced	1	2	1
Unknown	0	0	0
Total	3	10	5
Active	1	0	0
Inactive	0	4	5
Probably Active	0	1	0
Probably Inactive	2	5	0
Total	3	10	5

Venereal Disease

Blood tests were offered in conjunction with X rays in 1959 and 1961 surveys. The results are shown in Table 13. In 1959 the VDRL test was used and all testing was done in the State Board of Health Regional Laboratory. Although results were expedited, by the time they were obtained, a large number of reactors (71) were lost to follow-up. In 1961 the RPR (rapid plasma reagin) test which can be read within approximately 30 minutes was used. This resulted in only 10 persons being lost to follow-up.

TABLE 13

Results of Blood Test Surveys Among Migrant Farm Workers, Palm Beach County, Florida, 1959 and 1961

Results	1959	1961
Total Persons Tested	6097	3786
Positive Results	589	542
Brought or Returned to Treatment	82	173
Previous Treatment Adequate	250	277
Non-infected	186	82
Lost to Follow-up	71	10

Intestinal Parasites

Mention of intestinal parasites is warranted because of the extremely high incidence of infestation among agricultural migrants. History and clinical findings would indicate that most of the children have ascaris or pinworms at one time or another. During the course of the project, two Negro children in Belle Glade were reported to have choked to death because of ascaris infestation.

Health Services

Health services offered to the project population group included all of the basic public health services, i.e., communicable disease control, maternal and child health, chronic disease control, mental health services, environmental health services, health education, vital statistics and laboratory services. In addition, special health services were developed. In routine service programs, the project staff served to augment county health department staff; in other instances, programs were developed and operated by project staff in cooperation with consultant personnel.

Where service programs were developed specifically for the project population, the planning and operation of the programs embodied the concept of a multi-disciplinary approach. Several public health disciplines were concentrated in developing and administering health services in light of cultural and social patterns of the project population.

The following pages present brief descriptions of some of the health service programs offered to the project population group.

Family Clinics

In order to obtain data regarding the general health status of the people within the project areas, the project staff developed family clinics to which household groups within the project areas were invited. The development of the family clinics was an attempt to adapt a health service to social and cultural patterns of the project population and to determine the extent of acceptability of health services, predominantly preventive in nature, among the household groups within the project areas.

For two and a half years, family clinics were held at the Belle Glade Health Center once weekly in the evening usually from 6 to 11 p.m. During the course of the clinics, 862 men, women and children attended, receiving thorough physical examinations. The major criterion for an invitation to family clinics was that no obvious major health problem existed in the household group being considered for invitation. (Though therapeutic services were an obvious need, the focus of family clinics was toward prevention rather than cure.)

More than 90 per cent of the families who were invited to the clinics attended. This favorable response is attributed to: (1) the personal invitation and encouragement to attend and (2) the kind of reception enjoyed by the families when they attended the clinics. Preparation of the families was accomplished through home visitations by public health nurses, the medical social worker and, in some instances, the liaison worker.[5] Each visit by project staff members helped remind the families of their clinic appointments.

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[5] A discussion of the role of the liaison worker is found on pages 56, 57, 58.

A limited number of families was invited to each clinic. The families were given individual recognition by staff who had familiarized themselves with family histories. Courtesy characterized the manner in which families were treated; the medical examinations were thorough and unhurried.

The first few clinics were conducted with all members of the families being examined during the same evening. However, the staff found it more practical to examine adults and children on alternate weeks. Reasons for the change were: (1) families could be relied upon to attend two successive clinics; (2) adults could concentrate more freely on the examinations of their children when children and adults were not being examined during the same clinic; and (3) distracting confusion resulted when children and adults were examined during the same clinic.

It appeared that an invitation to the clinics became a status symbol among the project group. As the clinics progressed, families in the project areas heard about the clinics from families which had attended and began requesting appointments. It was not uncommon to have appointments scheduled several weeks in advance.

All of the project staff members participated in the clinics. In addition, two practicing medical doctors, a pediatrician and a general practitioner, who were from another community in the county, served as medical consultants in conducting the clinics. Prior to each clinic there was usually some opportunity for the staff and the attending physicians to exchange and discuss information concerning each of the families who were expected. A staff conference was usually held at the close of each clinic, but as the clinics lasted later into the night, the staff conferences became more a brief resume of the physicians' findings and less a staff conference.

It is felt that the family clinics served several valuable purposes. Perhaps the outstanding features are that the clinics demonstrated the value of planning health services in terms of the social, economic and cultural patterns of the population group at which the health services are directed; that planning must be done in great detail, leaving little to chance; that members of the sub-cultural group of which farm migrants are a part will respond to health services when time is taken to make careful, specific explanations and when the services become important to them personally.

Maternity Services

Maternity care programs of different varieties were attempted during the course of the project. The variation was more from necessity than by design. In 1951 a low-cost maternity plan went into effect which, by 1958, resulted in the elimination of the practice of midwifery in the western half of Palm Beach County. Through the years, differing procedures for the operation of the plan were attempted in efforts to devise a program in line with local medical resources and the size and complexity of the problem.

Currently, the low-cost maternity program requires that a patient pay $80 for physician and hospital services. Monthly antepartum examinations by private physicians, delivery in the local hospital and up to 48 hours hospitalization following delivery are included.

The procedure for operating the program is: Patients first come to a prenatal clinic conducted by public health nurses at the local health department. Here, certain laboratory tests are performed, patients are counseled and records are made. Patients then go to the local hospital where a determination of their eligibility for the low-cost program is made by the business manager of the hospital. Patients revisit the hospital on a day scheduled for maternity examinations conducted by local private physicians on a rotating service. Deliveries are the responsibility of the physican on call.

Though the maternity program which has been developed is less than ideal, a sizable majority of the Negro maternity patients seen at the Belle Glade Health Center were delivered in a hospital and were attended by a physician, as shown in Table 14.

TABLE 14

Delivery Plans Compared with Actual Delivery, 763 Negro Maternity Patients, Belle Glade Health Center, Palm Beach County, Florida, 1957-60

Place of Delivery	Delivery Attendant	Planned Delivery		Actual Delivery	
		Number	Per Cent	Number	Per Cent
Total		763	100.0	763	100.0
Hospital	Physician	684	89.6	629	82.4
Home	Midwife*	9	1.2	17	2.4
Hospital	Nurse	—	—	22	2.8
Unattended		—	—	29	3.8
Plans/Delivery not reported		70	9.2	66	8.6

**The absence of midwives in western Palm Beach County indicates that deliveries were performed elsewhere.*

Well-Baby Conferences

Public health nurses developed traditional once-weekly immunization clinics into well-baby conferences. Services, in addition to immunizations, included weighing and measuring the children and inspecting them for gross defects. Nursing conferences regarding formula preparation and the addition of solid foods were held with mothers who brought children under one year of age. Records concerning the services received at the conferences were given to the mothers; the importance of keeping health records was stressed.[6]

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[6] Though the mothers seemed to be appreciative of the health records, there has been no evaluation to determine whether or not the records are serving their intended purposes.

The response to the well-baby conferences demonstrated that, in some instances where ideal conditions do not prevail, traditional public health services call for expansion in order to provide needed services.

Morbidity

Few, if any, generalizations may be made concerning types and prevalence of illness in the project population. However, there were constant reminders of the need for therapeutic services among the group. Repeatedly, for example, people came to the health department seeking medical aid; public health nurses were called upon by migrants and non-migrants alike to "see what ail me" or to "look at my baby."

Concerning medical care, observations indicate that the project population felt, generally, that they could not obtain private medical care unless they had the "cash money" to pay for it.

Though the focus of project activities was predominantly upon the maintenance of good health and the prevention of disease, sickness among the population could not be ignored. Several attempts, with varying degrees of success, were made to provide therapeutic services.

Clinics for the ill were held weekly at the Belle Glade Health Center at intervals during the project. The public health physicians who attended the clinics reported that lack of opportunity for adequate follow-up was a major shortcoming of the clinics. Too, holding the clinics but once weekly severely limited the amount of service which could be given.

A pediatric diagnostic clinic was held twice monthly at the Belle Glade Health Center for approximately two years during the project. The pediatrician who attended the family clinics also attended the pediatric clinic to which special problems were referred.

The development of an out-patient medical service clinic in 1960 climaxed several years of effort directed toward alleviating medical care problems among the indigent group.

Local physicians and public health nurses attend the clinics which are held daily from 12:30-2:00 p.m. at the local hospital. It is the impression that the development of this medical service clinic is aiding substantially in meeting a pressing need.

CHAPTER FIVE

WORKING WITH MIGRANTS

A FUNDAMENTAL QUESTION which must be resolved in considering working in public health with migrant farm workers is: Do we really want to work with them?

Until public health agencies, individually and collectively, determine the extent of their responsibilities in this field and approach the difficult problems with objectivity and professional determination, we can expect a perpetuation of the inadequate activities in this field. The first essential, then, in working with migrant farm workers is the recognition and acceptance of a heavy responsibility and a determination to do something about it.

It is well to emphasize that this report offers no array of "gimmicks" nor special formulae purported to achieve desired ends. However, evaluation and modification of traditional assumptions, methods and techniques are important in public health work with migrants. We in public health must not assume that we already have all the answers pertaining to *how* to work with them. It is important to dispel the notion that the solution to problems of migratory farm laborers lies solely in increased budgets for the addition of more and more public health workers to carry on traditional health service programs in a traditional manner. In many instances "tried and true" methods of operation alienate rather than benefit migrants.

Understanding Migrants

The culture of the Negro migrants dictates, traditionally, accommodation to a dominant group. The phenomenon of accommodation manifests itself in a variety of ways. For example, public health workers should be aware that migrant workers are prone to give answers or to make comments which they feel are expected or acceptable. This makes it difficult to get at true feelings and accurate responses in interviews or conversations with migrants. A person who is interviewing a migrant may be misled very easily unless he is aware of the possibility of factual distortion brought about by the migrant's attempt to accommodate his answers to his interpretation of the expectations of the interviewer. Even when a migrant nods his head in response to a question or a statement by the interviewer, misleading information may be recorded unless the interviewer recognizes that when a migrant nods his head, this may be nothing more than accommodation. In order to avoid the accommodation pitfall, it is well to ask the same question in a variety of ways, rather than to assume that the initial response is accurate.

Migrants are oriented to the present more so than to the past or future. They do not seem to concern themselves with detailed planning to avert or to cope with critical situations. Behavior of migrants in this respect may be characterized as reacting to crises as they occur rather than by making deliberate plans or attempts to control or avoid crises. This is not to say that some planning does not take place; certainly it does, but there are few situations which would indicate that migrants think and plan much beyond the present and immediate future. This is not to say that migrants cannot be assisted in planning for emergencies, for they can. But public health workers should understand that planning in detail is not characteristic of migrants.

Migrants often lack basic knowledge in many matters. For example, it was found in the Belle Glade area that few migrants understood even the most basic aspects of the Social Security system. Understanding that they "had to have a card" in order to get a job, and that money was sometimes deducted from one's pay for it, was the extent of many of the workers' knowledge about the program. The latter aspect of the program was usually resented, and it is reported that the workers sometimes destroyed their cards in an effort to avoid the deductions. It was found that many of them had worked under several names and several Social Security account numbers; few of them seemed to realize the loss of benefiits which would result from such a practice. As they came to understand the benefits which could be derived from participation in the Social Security system, most of them could not understand why the government did not know of all the money they had paid under various names and account numbers. It was not uncommon to find Social Security recipients who had not received their checks for several months simply because they had not notified the agency of a change of address. Because of such conditions, the project staff devoted considerable time to explaining the Social Security program to the workers and assisting them in maintaining records of the amount that they had paid into the system.

In many other activities, few migrants appear to understand the necessity of maintaining records of any type. Their inability to produce records to verify the ages of their children has frequently led to difficulty in enrolling them in school. The older migrants have frequently experienced difficulty in establishing their eligibility for public assistance or Social Security benefits. To help them avoid such difficulties, the social worker assisted many of the families to secure birth records for all of their members. Throughout the project the migrants were encouraged to plan a safe method for preserving their birth, health and school records, insurance policies and other types of documents.[1]

Some migrants carry with them billfold-size health records which were issued to them by health departments in various Atlantic Coast States. It was found that the general interpretation of the health cards by migrants had more to do with a means of identification than with health. Few migrants indicated that they had ever been asked by health workers to produce a health record of any sort.

Communicating with Migrants

In the very early stages of the project, it became obvious to the staff that both verbal and written communication with the migrants would present difficulties. It could not be assumed that simply because both the staff and the migrants spoke "English" that they always understood each other.

Communicating with migrants is often a slow and difficult process. During interviews, migrants seem to answer *specific* questions, not seeing the questions as being related, i.e., they do not anticipate questions, generally. For example, if asked, "How many children do you have?", the migrant mother may reply, "Six." The interviewer may assume that the migrant mother lives in a household where she has six children of her own. But if the question is followed with, "Do all of your children live in the house (or room) with you?", the reply may be, "No'm, four of 'em lives with dey grandma." Again, the interviewer may assume that the migrant mother lives in a household with two children, her own. But if she is asked, "Do any other children live with you?," the interviewer may learn that there are children in the household in addition to the mother's children. The additional children may be her stepchildren, her boyfriend's children, her nieces or nephews or her own brothers or sisters. Another example is the response to, "Are you married?" While the respondent may say "yes" in all sincerity and honesty, further questioning may reveal that the respondent is not married to the man who is currently living with her and that her legal husband is elsewhere.

These examples are used to illustrate the importance of ***not assuming*** accuracy of interpretations of responses from members of the migrant group. Unless the possibility of distortion is recognized and procedures adapted to correct for the possibility, information not reflecting the real situation may be gathered.

Such a simple thing as determining an individual's correct name and age can be a major task. Birth certificates were often not available even for the younger children; for the older adults, they were almost non-existent. It was not unusual to find individuals who were known by more than one name. Since the individual's correct name is essential for the maintenance of adequate heath records, the staff attempted to find ways of determining it.[2] To be reasonably certain of a patient's correct name, it was found necessary to discuss it with him. During such discussion the migrant was usually asked to present his Social Security card. If one were produced, he was asked if he were known by the name which appeared on the card. If the individual did not possess a Social Security card, he was asked, "What do your friends call you?" In either event, the individual was asked if he were known by any other name. Thus, the staff was usually able to determine the individual's correct name and, in many instances, to convince him of the necessity of using this name.

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[1] During the early stages of the project a number of families were given plastic record containers for this purpose. It was found, however, that the containers were used for diaper bags more frequently than for preserving records.

Although some progress was made in determining an individual's age, this was a problem which was never completely solved. The project staff found that a number of facts contributed to the above situation. First, the importance of maintaining records regarding births, names, ages and so forth was never fully understood by the majority of the migrants. Next, family instability of this population group has played a significant role in confusing the identity of individuals. Among the migrants, the mother can give the newborn child any name she wishes. If she is married and there is no question of paternity, the newborn child takes the name of her husband. For children born out of wedlock, a number of practices are followed. If the mother has had a legal marriage which has been terminated, she may continue to use her former husband's name and give it to the newborn. A more common practice, however, is that of giving the mother's maiden name to children born out of wedlock. In some instances, however, the child is given its father's name although no father is named on the birth record. The problem is further complicated by the inability of physicians, nurses and others who attempt to record births, to communicate effectively with the migrant mother.

Difficulty of communication with persons outside their own cultural group is characteristic of many migrants. Experience has indicated that many are able to express their problems only when helped to do so by the person to whom the problem is being told.

There is need to recognize that the group, generally, is poorly educated. Many are functionally illiterate; many who attended schools did not go beyond seven grades. Their health concepts are very often quite different from those held by persons outside their culture.

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[2] In addition to the confusion which the migrants' casualness concerning names caused for the local health and welfare agencies, it was found that the migrants themselves often lost social security and welfare benefits, had difficulty in enrolling their children in school and encountered numerous other difficulties because of the inability to establish their true identity.

In a study conducted among selected adults attending family clinics, 42 persons were interviewed to determine their concepts of immunizations, diarrhea and intestinal parasites. These three health entities were selected because of emphasis usually placed by health agencies on "educating the community" about them, and because these three health entities are problem areas in the cultural group of which migrants are a part.

Results of the study indicate that most of the group ranged from no knowledge at all to a vague understanding of the three health entities. Table 15 is a tabulation of findings.

TABLE 15

Concepts of Selected Health Entities, 42 Negro Patients, Belle Glade Health Center, Palm Beach Country, Florida
1958-59

Health Entity	Total Number of Respondents	Number Reporting Vague, Erroneous or No Knowledge	Per Cent of Total
Immunization	42	22	54.4
Diarrhea	42	25	59.8
Intestinal Parasites	42	39	92.8

Widespread ignorance concerning immunizations, diarrhea and intestinal parasites was revealed. It should not be assumed that respondents who revealed having some knowledge of the health entities were well-informed or that no further need for education regarding the three health entities was indicated.

Concepts commonly expressed were: (a) Immunization: Most respondents believed that "shots are good." They associated immunization with the broad field of health. Very few revealed any accurate knowledge of the purpose of immunizations. (b) Diarrhea: Few seemed to associate diarrhea with illness, though most were familiar with the phenomenon of "loose bowels" or "running off." Very few revealed any knowledge of causes of diarrhea. (c) Intestinal Parasites: Most of the respondents had, at some time, had experiences with "worms"; very few associated them with health in any way. Most accepted intestinal parasites as being rather normal, ascribing their presence to "eating too much sweetnin' or grease."

The health expectations of migrants may be described as being fatalistic in nature. There is an apparent expectation of a certain amount of illness during the course of a year. Such illness is accepted as being normal, not calling for any particular concern or action.

In addition to the barriers presented by differing concepts of health entities, communication may be further complicated by assuming that migrants have an effective understanding of public health terminology. It was found that health pamphlets having a readability level of more than fourth grade have little value to migrants. Migrants were unable to read certain words used in conventional health pamphlets. A vocabulary study was conducted among 43 selected adults who attended family clinics. The median school grade completed by the group was 5.5. Each respondent was asked to review a list of words and to read aloud those which he could pronounce and to omit those which he could not pronounce. Results of the study are shown in Table 16. The words appear in ascending order of difficulty, e.g., 37 (86.0 per cent) of the respondents did not read the words "physician" or "parasite."

TABLE 16

Selected Health Terms in Order of Non-readability for
43 Negro Patients, Belle Glade Health Center,
Belle Glade, Florida, 1958-59

Word	Number of Respondents Not Reading Word	Per Cent of Total Number of Respondents
Physician, parasite	37	86.0
Immunization	36	83.7
Nutrition	35	81.4
Sewage	34	79.1
Communicable	33	76.7
Prenatal	32	74.4
Pregnant	27	62.7
Rot	26	60.5
Examination	25	58.1
Mental	22	51.1
Dental	19	44.1
Germs	18	41.9
Decay	17	39.5
Catching, illness	14	32.5
Public, stool	13	30.2
Dentist, waste	12	27.9
Shots, vegetables, clinic	11	25.6
Nurse, check-up	9	20.9
Worms	8	18.6
Healthy	7	16.3
Child	6	13.9
Eyes, teeth	5	11.6
Greens, doctor, food	4	9.3
Fruit	3	6.9
Sick, insect	2	4.6
Well	1	2.3

Thus health pamphlets containing most of the words appearing in the foregoing list may be relatively useless if members of the group are expected to read the material. It may be unrealistic even to expect members of the group to read clinic signs. For example, almost 75 per cent of the respondents did not read the word "prenatal," indicating that migrants should not be expected to know when prenatal clinics are held simply because "It says so on the sign outside the building."

The concept of preventive medicine is rather foreign to migrants. Though many of their children have been immunized, the reason for parental motivation to this end is open to question. Migrants apparently rarely associate immunizations with preventing diseases. To most, there is little or no differentiation among "baby shots," "cold shots" or "blood tests." The common denominator is the needle, and few migrants seem to remember details other than having had a "shot."

To many migrants public health personnel are grouped into two categories: doctors and nurses. If the public health person is a male, migrants perceive him as being a doctor; if female, the public health person, to migrants, is a nurse. "Doctors" and "nurses," to whom migrants refer, may not always be doctors and nurses as we perceive them. The roles into which migrants cast public health persons have much more to do with curing rather than preventing diseases.

Migrants are not organized in the sense of holding memberships in civic clubs, groups and societies usually described as community organizations. In this sense, migrants are "groupless." Negro ministers in the Belle Glade area expressed their feeling that fewer than 10 per cent of the migrants attend church while in this area. A few migrants attend PTA meetings and church functions, leaders of which expressed interest in encouraging more migrants to attend, adding, "We've tried to get them (migrants) to come, but they just won't."[3]

The "grapevine" method of communication seems to be effective in reaching migrants. Crew leaders utilize this method when forming crews in preparation for the annual trek northward. As one crew leader expressed, "I puts out the word when I'm leaving. I tells the peoples, and they tells other peoples. Soon they all knows about it." The grapevine method involves interpretation by the group. At one stage of the project, attendance at prenatal clinics declined sharply. Investigation revealed that women were under the impression that only married women could "come to the clinic." This incorrect impression apparently stemmed from the practice of inviting families to family clinics; the distinction between family clinics and prenatal clinics had not been clarified, leading the women to believe that marriage was necessary in order to receive prenatal clinic services.

The Leadership Role of Crew Leaders

In the community at large, individuals who are usually referred to as being "Negro leaders," e.g., Negro merchants, ministers, school teachers, supervisory personnel, etc., were, at times, targets for expressions of dislike by migrants. Upon occasions, some migrants freely expressed their resentment of specific individuals among this so-called leadership group of the Negro community. The justification, if any, for such expressions of resentment was not determined. Effective leadership of migrants should not be assumed to be present in the Negro community; there was in the project area a notable lack of it from the Negro "leadership group."

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[3] Interviews with migrants suggest that the meetings were not interesting or that the meetings lasted too long.

The only semblance of leadership prevalent among the migrant group is the relationship which exists between crew leaders and workers. This is one in which workers depend upon crew leaders in a manner similar to sharecroppers being dependent upon landowners. The crew leader-worker relationship in the Belle Glade area, and in certain other sections of Florida, is not the same as exists in other Atlantic Coast States. As reported earlier, the work pattern in the Belle Glade area is "day haul"; not permanent crews. The role of crew leaders in Belle Glade is predominantly supervisory in nature; in other parts of the stream, however, they have responsibility for a specific crew of workers for the harvest season.[4]

Early in the project the possibility of utilizing crew leaders as "points of entry" to migrants was explored. Educational activities directed specifically at crew leaders were encouraging in their results. Night meetings were held once weekly for approximately 12 weeks during the farming seasons of 1957-58-59. The meetings usually lasted for an hour, beginning at 8:30 p.m. Discussion topics were selected by the crew leaders from within a framework suggested by project staff members. Topics were usually health centered and included: Using Health Resources, Communicable Diseases, Sex Education, Family Relationships, Intestinal Parasites and Environmental Sanitation.

At one stage of the project, four crew leaders voluntarily participated in a small project designed to assist crew leaders to establish effective relationships with public health departments in various locations along the Atlantic Coast. The volunteer crew leaders were instructed: (1) in how to locate health departments; (2) in how to establish relationships with public health personnel; and (3) to offer their own assistance to public health personnel who may wish to locate specific individuals within the crew. Each crew leader was given a letter of introduction which stated that the crew leader was participating in a special health project in Florida. When the crew leaders returned to Belle Glade the following season, they were interviewed to evaluate the experiment. Generally, results were encouraging. All four crew leaders reported the letters of introduction to be helpful. In one case, a crew leader reported that health department personnel were "cool" to him at first, but "when I pulled my papers on 'em (showed his letter of introduction), they was nice." Another crew leader reported his opinion of the letter of introduction as being "the finest thing that ever happened." He reported that his was the only crew in camp to receive health services, attributing this to his using the letter of introduction. He reported further that workers left other crews to join his when they realized he had an entree to health services. This unexpected "advantage" no doubt influenced his high regard for the letter of introduction.

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[4] Some crew leaders work as "field walkers" or overseers in the fields; some transport workers to and from the fields: some do not have supervisory roles but become day laborers when they return to Belle Glade.

The degree to which migrants are dependent upon crew leaders as the crews move along the Atlantic Seaboard is important. As one crew leader expressed, "They comes to me for everything." A member of the project staff followed five crews from Florida to the Delaware-Maryland-Virginia peninsula during the summer of 1960. His observations were that the crew leaders were key persons in assisting migrants to obtain health and medical care; that when migrants felt the need for health and medical care, it was to the crew leader they turned. Crew leaders assisted them, predominantly, in one or both of these ways: (1) by providing transportation to and from physicians' and dentists' offices, hospitals, health departments and (2) by arranging for payment of fees by making direct loans to migrants, by direct payment, or by "standing good" for expenses incurred.

Experience indicates that organization of crew leaders for health leadership is a feasible objective; that crew leaders, at least some of them, are receptive to health education efforts, and that some crew leaders reflect a sincere desire to assist in improving and maintaining the health of migrant farm workers. Experience suggests that an intensive effort to reach crew leaders with health education on a large scale would be fruitful in terms of reaching the thousands of farm workers who are dependent upon them.

Building Relationships with Migrants

Building relationships with individual migrants stands out as basic to efforts directed toward altering their health behavior. One of the primary entrees to the migrant is a demonstration of sincere interest in him as a person—a luxury few migrants enjoy. It is felt that not all public health workers approach the health problems of migrant farm workers in a manner which reflects sincere interest in the migrant as an individual.

It is easy to propose that we "establish a comfortable relationship" with migrants. But how do we accomplish this? It should be remembered that most migrants are much less sophisticated than our methodology. Traditionally he is more accustomed to being *told* rather than *asked;* he feels comfortable in situations which to persons outside his culture may not seem to be in keeping with "good technique." Addressing a client or a patient by his first name is presumptuous and in poor taste to most professional workers. In many cases, the objection is valid. However, when we consider the expectations of the migrant, we may find that strict adherence to our professional culture serves to create an atmosphere which, to the migrant, is artificial and insincere. The assumption that we always impart dignity to an individual by prefixing his surname is open to question. Dignity may also be imparted by using the given name of the migrant, which is a familiar situation to him, in a sincere, non-patronizing manner. We cannot assume that either approach always helps or hinders the rapport-building process with migrants. The approach depends upon the nature of the situation and the individuals involved. The purpose in mentioning such a seemingly unimportant detail is to emphasize the need for *flexibility* on the part of public health workers in building relationships with migrants and other members of the same cultural group.

Migrants often appeared to feel indifferent toward project personnel and toward the health services being made available. Closer investigation indicated that such an attitude was the result either of feelings of resignation regarding problems which migrants felt had no solution or were based upon previous unpleasant experiences with community agencies. In the latter case, attitudes changed as the migrant realized that he would not be humiliated or "brushed off." When migrants became aware of the staff workers' interest in them as *individuals*, through a non-patronizing approach, it became possible for the staff to assist them in developing solutions to some of their problems.

The relationship of public health workers to the community at large has importance in establishing relationships with migrants. It is necessary to guard against becoming identified with persons in the community who are disliked or distrusted by the migrants. Identification with persons rejected by migrants may well result in alienating migrants from health programs. It has been observed that, in some instances, individuals who seem to have an abounding interest in and knowledge of migrants are the very persons whom migrants reject vehemently. The individuals referred to here were Negroes of considerable status and who were called upon by the community to "speak for" the migrants and to appraise the migrant situation in the community. In the same vein, the community tends to reject individuals overly possessed with zeal and determination who crusade about, "organizing the community" in the interest of migrant welfare. Farmers, growers, labor camp operators and others in the community may be reluctant to lend support to public health efforts identified with crusades or campaigns designed to "do something" but which have ignored community feelings and attitudes and which were conceived in ignorance of the values and concepts of the migrant group. Obviously, if public health workers allow themselves to become closely identified with individuals or groups described above, the possibilities of establishing effective relationships with either migrants or the community will be less than favorable.

The Liaison Worker

Certain difficulties in the development of effective relationships with migrants were anticipated, one being the difficulty of bridging cultural gaps which exist between public health workers and migrants. In an attempt to overcome certain barriers presented by cultural differences, an experimental position called "liaison worker" was incorporated into the original project plan. The liaison worker selected for the project was a Negro female in her early thirties, married and the mother of two children. Her formal education consisted of completing high school in Belle Glade. Prior to joining the project staff, she worked as a clinic aide at the local hospital.

The role of liaison worker, as envisioned by the designers of the project, was basically one of cultural interpretation, i.e., to help the other members of the staff understand the behavior of migrants and vice versa. As a member of the cultural group of which migrants are a part, the liaison worker provided a channel of two-way interpretation between migrants and project staff members. Migrants readily identified with and confided in the liaison worker. This was a major asset in providing health services to the migrant group. The liaison worker was able to "fit in" with migrants wherever they gathered, and her identification as a public health worker helped to reassure migrants that the "folks at the clinic" (public health staff) were genuinely interested in them and would treat them "nice."

Feedback information relatively inaccessible to the professional staff was made available through non-professional social relationships which existed between the liaison worker and the migrants. Such information was made available to all staff members and was utilized, as indicated, in providing services to specific individuals or in general planning and evaluation of health service programs.

During the course of the project, the liaison worker was trained to conduct interviews with migrants and has participated, under close supervision, in certain studies conducted by the project staff. The characteristic of being non-professionally trained was a two-edged sword. If too well trained, the liaison worker risked losing her identity with migrants; on the other hand, there was danger in placing confidence in her observations and opinions disproportionate to her training.

In the community, the liaison worker functioned in a social work capacity, assisting a local committee concerned with migrant relief to determine assistance needs of the migrant population. To many migrants, the liaison worker became a *contact person* who could help them obtain various forms of assistance through community service agencies. There were many times when migrants referred other migrants to the residence of the liaison worker to "see about gettin' a little help."

The liaison worker functioned most effectively when given specific assignments closely supervised by one or, at most, two members of the staff. For example, the liaison worker was assigned to visit the local hospital each working day to obtain information pertaining to newly born Negro infants. During the hospital visits, she had the opportunity to talk with the mothers and could explain the importance of early immunization and encourage the women to have their babies immunized. This prepared the mothers for subsequent advice given by the public health nurses during home visits.

Another time the liaison worker was assigned to visit beauty shops, barber shops and a local movie theater where health leaflets especially designed for migrants had been placed.[5] The objective of these visits was to observe the interest, if any, in the materials and to note any relevant comments. It was learned that there was considerable interest and that questions and comments regarding the content of the leaflets were generally directed to the proprietors of the establishments. From time to time, proprietors contacted the liaison worker and requested additional supplies, commenting that some of the migrants expressed that they had never really understood "bad blood" (syphilis) before reading the material.

At the clinics held at the health center, the liaison worker served in a variety of capacities. At times, she assisted physicians and nurses during examination of patients; in a receptionist capacity, she welcomed the patients to the clinics, showed them around and made them feel at home. She also cared for children when mothers and fathers were in conference with other members of the staff. Generally, her role at the clinics was quite undefined and non-specific, advantageously.

It is emphasized that the activities of the liaison worker were carefully guided by professional staff members .The most beneficial activities of the liaison worker were those in which the staff utilized her services as a *resource* rather than as additional arms and legs to perform perfunctory tasks for professional staff members.

The liaison worker was very effective in the role designed for her — that of bridging cultural gaps. In some cases public health personnel have been somewhat reluctant to accept the concept that non-professional persons may be valuable in providing health services. The reluctance appears related to the feeling that acceptance of such a concept implies weakness on the part of professional personnel; that acceptance of the concept is an admission of incompetence to deal with persons who are culturally different from professional public health workers. Experience here suggests that purposeful measures taken to avert or circumvent barriers presented by differences between cultures is a sign of insight—not weakness. The value of having a staff member with whom migrants readily identify and in whom they confide—the absence of which compounds the difficulties of providing health services to migratory farm workers —is recognized.

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[5] Sample copies of the health leaflets may be obtained from the Division of Health Education, Florida State Board of Health, P. O. Box 210, Jacksonville, Florida.

Developing Health Programs for Migrants

If health services are to be made more available to migrant farm workers, there must be recognition of barriers which reduce or remove the availability of health services to them. The project has been moderately successful, we believe, in determining ways and means of overcoming certain barriers related to social and cultural characteristics of the migrant group. Experiences during the course of the project indicated a need for flexibility in planning, implementing and operating health service programs for migrants. This implies the probability of calculated departures from tradition; a willingness to relax the grip of *status quo*, and for critical appraisal of current health service programs as they relate in design and operation to social and cultural patterns of migrant farm workers.

In planning health service programs for migrants, it is important to consider their work patterns. Usually, migrants leave their quarters between 6 and 7 o'clock in the morning to get ready for the day's work. Migrants in the Belle Glade area rarely begin picking beans before 10 a.m. but they spend several hours in the process of milling around the loading zones, being transported to the fields and waiting until the beans are dry enough to pick. The time of day when migrants complete their work follows a less routine pattern and is difficult to predict. Sometimes, migrants leave the fields in the early afternoon; other times, much later. One cannot assume, however, that migrants will have returned to their quarters before 6 to 8 p.m. It is recognized that patterns elsewhere will vary widely according to locale and crop season. The work patterns of migrants and the availability of health services need to be compatible. However, health departments, traditionally, open their doors between 8 and 9 a.m. — an hour or two after migrants have left for the fields. Between 4 and 5 p.m., health departments usually close —an hour or more before migrants leave the fields. When can migrants come for indicated health services?

In discussions of this problem, comments have been made to the effect that migrants could make arrangements to be at the health department during the regular hours if they really want health services. It is suggested that such attitudes were developed without benefit of realizing the reluctance of migrants to give up a day's income to take advantage of a preventive health service which may well have little personal meaning. Health services need to be offered at a time when migrants can be expected, realistically, to use them.

Health department schedules, traditionally, are categorized into such services as immunization clinics, chest X-ray clinics, blood test clinics, dental clinics, prenatal clinics, etc. Further specialization occurs in specifying the time of day, day of week and/or month when the services are offered. It is not unusual for a specific service to be offered, for instance, from 8-10 a.m. on the first and third Tuesdays of each month or from 2-4 p.m. every other Friday. Such health service schedules can be learned and conformed to by some population groups, but it is unrealistic to expect such a degree of sophistication to be present in migrant farm workers. Appreciating some of the characteristics and limitations of migrants, it must be realized that a highly specialized health service schedule places unrealistic demands upon many members of the migrant group. Such demands have the effect of making health services relatively or totally inaccessible to migrant farm workers.

When migrants fail to keep an appointment for a specific health service, the unkept appointment is often attributed to a lack of interest or to irresponsibility on the part of the migrant. It is suggested rather that each procedure needs to be examined to determine whether or not it includes unintentional barriers to the delivery of the particular service. Some agencies, for example, utilize the mails for some purposes in a public health procedure. In doing so, the agency assumes: (1) that the mailing address of the patient is accurate, (2) that if the patient has moved, he left a forwarding address, (3) that the patient knows how to read, and (4) that he will have no difficulty in understanding the contents of the letter. Such a procedure is effective with many people, but it is quite unrealistic to expect the sophistication of more than a few migrants to match that of such a system. A case is recalled where a migrant woman received a postal card telling her of a clinic appointment; the appointment was unkept. A follow-up visit revealed that the woman did not understand the meaning of "4-17-57" which appeared on the card to indicate the date of the appointment. The implications are evident.

Systems of providing health services for migrants should include flexibility to the degree that, if necessary, a variety of health services may be offered during one visit to the health department. Rigid adherence to clinic schedules has the effect of refusing service to persons other than those whose service requests coincide with the dictates of the schedule. Consider the amount of time and effort necessary to teach migrants the desirability of obtaining certain health services. Unless additional time and effort are expended to teach them the exact time at which the service is offered, and unless migrants succeed in conforming to the schedule, it is likely that they will find the service unavailable to them when they finally arrive at the health department. There is no guarantee, certainly, that migrants will return to a health department at the "appointed hour."

Effective public health work with farm migrants depends, at least in part, upon recognizing that the burden of proof must not be placed entirely upon the migrants; that we must orient ourselves to the cultural peculiarities of the ethnic group which, in the main, spawns Atlantic Coast farm migrants.

If it is recognized that the health behavior of farm migrants is logical within their culture, then perhaps the tendency to accept stereotypes will be supplanted by an insistence that schedules consider realistically the needs, possibilities and convenience of the migrant clients.

In summary, effective public health work with farm migrants demands a working knowledge of the nature of their behavior; that our expectations of them be realistic; that the demands which we place upon them be acceptable within their own culture.

Migrant Children in Belle Glade

CHAPTER SIX

SUMMARY AND CONCLUSIONS

THE PHRASE "on the season" is used by Negro migrant farm workers to denote their engagement in seasonal farm work. Along the Atlantic seaboard, farm migrants are on the season from southern Florida to upstate New York, moving from place to place in response to the demands of seasonal farm activities. It is estimated that some 50,000 workers comprise the migratory farm force known as the "Atlantic Coast Migrant Stream."

Florida is considered to be the "home base" for Atlantic Coast migrants. The public health implications of the annual influx of farm migrants have been of considerable concern to the Florida State Board of Health and the county health departments. In 1956, the Children's Bureau of the U. S. Department of Health, Education. and Welfare provided a grant to the Florida State Board of Health for a five-year program to develop public health services adapted to the social and cultural patterns of migrants and to provide the migrants with health services. The grant extended from July 1956 until July 1961.

The project was located in Belle Glade, Florida, and functioned as a part of the Palm Beach County Health Department. A multidisciplinary public health team comprised the project staff: two public health nurses, a public health educator, public health nutritionist, medical social worker, part-time sanitarian, liaison worker and secretary. Two private physicians served as medical consultants to project activities.

The study aspects of the project were secondary to the service functions. This report is concerned with observations made and data collected incidental to the provision of health services to a selected group of farm workers. Some of those served were migrants, some non-migrants, but all were in the same socio-economic and cultural group.

More than 50 per cent of the study group were born in Georgia; the median grade completed in school by adults was 6.4. The mean number of persons per household (excluding single person households) was 5.3. According to reported marital status, approximately 75 per cent of the adults were married.

Most of the group came to Belle Glade from rural agricultural communities. Their inability to secure regular employment in their home communities was the usual reason for their turning to migratory farm labor. Here, as in their home communities, work consists of unskilled manual labor in planting, tending, harvesting and packaging farm crops.

Life in the stream proved to be more complex than life "back home." The migratory life offers few, if any, of the securities of life of the stable rural community. The migrant faces repeated adjustment to many different communities; he is confronted with problems in health, education and economics in his migratory life for which he is unprepared. In his former situation there was usually a dependency relationship with some person, perhaps his employer, to whom he could turn for help. In contrast, the migratory life demands that he be much more independent and self-sufficient.

In the two geographic areas where activities of the project were concentrated, the people lived in crowded conditions. Living quarters were small; households large. More than half of the households lived in one room (150-200 sq. ft.) per household.

A survey was conducted by the project sanitarian of 320 establishments which house migrants in western Palm Beach County. His observations indicate: (1) that there were fewer deficiencies in housing where someone was employed to give general supervision to the premises; (2) fewer sanitation problems occurred where garbage collection and disposal was the responsibility of each household as opposed to central storage and collections; (3) some of the abuses usually attributed to deliberate destruction to housing and related facilities seem to be caused by migrants' attempts to make their quarters more functional.

Complete physical examinations were given to 862 men, women and children invited to attend well-family clinics. Those observed proved to be approximately equally divided between migrants and non-migrants; there was no marked difference in the findings. The most frequently encountered abnormalities were nutritional problems, dental problems, other abnormalities in the mouth or throat and disorders of the genitourinary system, each of these occurring in from 10 to 20 per cent of those examined.

Negro maternity patients receiving services at the Belle Glade Health Center had three prominent characteristics: (1) frequent pregnancies; (2) lack of adequate prenatal care; (3) insufficient funds to afford private care. Impressive observations related to health were: (1) low hemoglobin; (2) extremes of blood pressure; (3) low incidence of positive serology (syphilis). Most of the group reported for prenatal care late in the second trimester of pregnancy.

Detailed physical examinations for signs of good or poor nutritional status were not conducted. However, information obtained though general physical examinations showed evidence of scurvy, rickets, nutritional anemia and marasmus. One case of kwashiorkor was found. Dietary studies conducted during the project suggest that intake of milk and milk products, green and yellow vegetables, citrus and other fruits is inadequate; there was found to be an adequate intake of meats, meat alternates, starches, fats and sweets.

Three chest X ray surveys were conducted among the farm labor population during the project. Through 13,067 X rays, 13 new cases of tuberculosis were found. During the course of the project 84 Negroes from the Belle Glade area were admitted to tuberculosis hospitals for treatment. In 1958-59, tuberculin tests (0.0001 mg. PPD) were given to 1462 Negro school children. Two hundred and two (13.8 per cent) reacted positively. One hundred ninety-eight (93.06 per cent) of the reactors were X-rayed. The total number of reported contacts was 893. Results of follow-up among reactors and contacts revealed four cases of primary tuberculosis.

Blood tests were offered in conjunction with the chest X-ray surveys in 1959 and 1961. Of 9883 blood tests, 1131 (11.4 per cent) were positive; 255 were brought or returned to treatment; 527 had previous adequate treatment; 268 were non-infected; 81 were lost to follow-up.

History and clinical findings indicate an extremely high incidence of intestinal parasite infestation among the project population. During the project, two children were reported to have choked to death because of ascaris infestation.

A dental survey among 138 Negroes living in one of the project areas revealed a total of 662 DMF.

In order to obtain data regarding the general health status of the project population, family clinics were held at night. More than 90 per cent of the families invited attended. This was attributed to: (1) the personal invitation and (2) courteous treatment of the patients at the clinics. It is felt that the family clinics demonstrated the value of planning health services in terms of the social, economic and cultural patterns of the migrant group.

Maternity care programs of different varieties were attempted. Currently, a low-cost program is in operation wherein a patient pays $80.00 for physician and hospital services. There are no practicing midwives in western Palm Beach County. The records of 763 Negro maternity patients of the Belle Glade Health Center, 1957-60, indicate that 629 (82.4 per cent) were delivered in a hospital and attended by a physician.

Morbidity clinics were developed in 1960. Staffed by private physicians and held at the local hospital, these are aiding in meeting a pressing need.

Effective public health work with farm migrants depends in large measure upon a willingness to develop and to implement health services in terms of the social and cultural patterns of the migrant group. In order to accomplish this, it is requisite that we recognize and understand the cultural differences which exist between migrants and professional public health personnel. The designers of this project anticipated such cultural differences and incorporated into the original plan an experimental role, that of liaison worker, in an attempt to overcome cultural barriers. The project liaison worker identified culturally with the migrant group. She was successful in assisting the project staff to understand the behavior of migrants and in interpreting the professional staff to the migrant group.

Utilizing knowledge of the work schedules of migrants, the staff offered some health services to migrants at night — a time when they could, realistically, be expected to attend clinics. Too, a variety of health services was offered during one visit to the health department, reducing the necessity for repeated visits.

It was found that the most influential leadership of migrants rests with crew leaders. Efforts to bring groups of crew leaders together for training in health matters were reasonably successful; organization of crew leaders for health leadership proved to be a feasible objective. Investigations indicate that crew leaders are key persons in assisting migrants to obtain health and medical care. Experience suggests that intensive efforts to reach crew leaders with health education would be fruitful; through them the thousands of migrants who are dependent upon them could be aided.

The project reported in the foregoing pages raised many more questions than it answered. Perhaps one of the more significant contributions is the knowledge that migrant farm workers need not be relegated to a social purgatory, being impossible to reach by public health efforts. No less important is the realization that effective public health work with migrants depends to a great degree upon the willingness of professional public health workers to increase their own knowledge of the culture and to be genuinely flexible and realistic in their practice of public health with farm migrants.

The data do not point to specific health problems which seem to be peculiar to migrants. This is not to minimize the task but to suggest that the health problems of migrants represent but the "tip of the iceberg" and that similar problems of greater magnitude exist throughout this socio-economic and cultural group regardless of migration status. It seems apparent that the basic problems of migrant farm workers do not originate upon entrance into the migrant stream but have their origin in the pre-migratory environment. Farm workers become migratory mainly as a *result* of problems. Migration, in and of itself, can hardly be pointed to as the sole cause of the problems though it is evident that some of them are associated directly with mobility. This observation suggests a need for concerted attention directed at the migrant reservoir areas —the pre-migratory environment—as well as the migrant stream.

Observation and experiences during this project suggest strongly that the problems faced by migrant farm workers do not lend themselves to solution if they are treated only in part according to the interests and responsibilities of governmental and/or private organizations. The problems of migrant farm workers are not *a* health problem; not *a* labor problem; not *a* welfare problem, nor *an* agricultural problem. They are social problems, sufficiently complex to tax the very best resources available to any community, state or organization. Without consolidation of effort directed at the basic causes of the problems, it is probably more accurate to speak in terms of *alleviating* rather than *solving* the problems which the phenomenon of migratory agricultural labor brings to our attention.

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